TWO RIVERS FAMILY DENTISTRY

To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need any assistance, please ask us. We will be happy to help.

PATIENT INFORMATION

Name: Last _____First_____ MI ___ Title: Mr/Ms/Mrs
Home Address: _____City _____ST____ Zip _____
Mailing Address: _____City _____ST____ Zip _____
E-Mail Address: _____ Cell Ph: _____ Home Ph: _____
Work Ph: _____ Ext. _____ Patient's Name of Employer: _____
Gender: Male __ Female __ Family Status: Minor __ Single __ Married __ Widowed __ Other__
DOB: ____/____/____ SS#: _____-_____-____ State ID/License #:_____
If College Student, F.T. / P.T. Name of School: _____City _____ ST ___

PARENT'S INFORMATION

Mother's: Last _____ First _____ MI ___ Title: Mr/Ms/Mrs
Home Address: _____ City _____ ST ____ Zip _____
Mailing Address: _____ City _____ ST ____ Zip _____
E-Mail Address: _____Cell Ph: _____ Home Ph: _____
Work Ph: _____ Ext. _____ Name of Employer: _____
DOB: ___/___/____ SS#: ____/____/____ State ID/License #: _____
Nearest relative not living with you: Name _____ Ph#:_____
Relationship _____
Father's: Last _____ First _____ MI ___ Title: Mr/Ms/Mrs
Home Address: _____ City _____ ST ____ Zip _____
Mailing Address: _____ City _____ ST ____ Zip _____
E-Mail Address: _____Cell Ph: _____ Home Ph: _____
Work Ph: _____ Ext. _____ Name of Employer: _____
DOB: ___/___/___ SS# ____/____/____ State ID/License #: _____
Nearest relative not living with you: Name _____ Ph#: _____
Relationship _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured(EMPLOYEE) _____ DOB ___/___/___ Relation to Patient ____
SS# / Certificate / Member ID#: _____ Group #: _____
Name of Employer _____ Phone #: _____
Employer Address: _____City _____ ST ___ Zip _____
Insurance Co. _____ Ins. Co. Ph #: _____
Address _____City _____ST____ Zip _____

-OVER-

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured(EMPLOYEE) _____ DOB ___/___/___ Relation to Patient _____
SS# / Certificate / Member ID#: _____ Group #: _____
Name of Employer _____ Phone #: _____
Employer Address: _____ City _____ ST ___ Zip _____
Insurance Co. _____ Ins. Co. Ph #: _____
Address _____ City _____ ST ___ Zip _____

MEDICAL/DENTAL HISTORY

Allergies: Penicillin __ Local Anesthetic __ Jewelry/Metals __ Other _____
If other please explain _____
Have you or are you currently taking any bisphosphonate osteoporosis medication?YES__ NO__
Do you take aspirin or blood thinners? Yes __ No __ If Yes, dosage and why? _____
Are you subject to prolonged bleeding? Yes __ No __
Medications currently taking: _____
Do you smoke? Yes __ No __ Do you chew tobacco? Yes __ No __
Are you pregnant? Yes __ No __ Birth control? Yes __ No __
Have you or anyone in your family been diagnosed with diabetes? Yes __ No __
Have you ever had any major operations? Yes __ No __ If Yes, Name, Address, phone # of physician: _____
Have you had to take a Pre-Medication for dental visits? Yes __ No __

Indicate which of the following you have had or have at the present

Anemia/Blood Problems	___	Diabetes	___	Kidney Disease	___
AIDS or HIV Positive	___	Eating Disorders	___	Radiation/Chemo	___
Artificial Heart Valve	___	Heart Murmur	___	Respiratory Disease	___
Asthma	___	Hepatitis	___	Rheumatic Fever	___
Cancer	___	High Blood Pressure	___	Sinus Problems	___
Congenital Heart Defect	___	Hip/Joint Replacement	___	Stroke	___

If you are aware of any handicaps, health, developmental or psychological problems please describe: _____
_____

I understand that co-payments, deductibles and payments for charges not covered by insurance are due when services are rendered. A monthly service charge of 1.5% will be added to all accounts not paid within 60 days. If I have insurance, I hereby authorize payment directly to Two Rivers Family Dentistry of the group benefits otherwise payable to me.

_____ _____
Patient Signature Date Parent or Guardian if under age 18 Date