Rho Family Dentistry

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Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date: _____
Email Address: _____
Name: _____
Last First Mi

Birthday _____/_____/_____Age: ____ □ M □ F
Home Address: _____

_____
SSN: _____
□ Single □ Married □Divorced/Separated □Widowed
Hm #: _____ Cell# _____
Wk #: _____ DL# _____
Employer: _____
Employer's Address: _____

_____
How long there? _____Occupation: _____
Where & Best times to reach you? _____
Whom may we thank for referring you? _____

_____
Other family members seen by us: _____

_____
Previous / Present Dentist: _____
Person Responsible for Account: _____
Any other information you would like to share with us: _____

_____
_____

SPOUSE INFORMATION

His/Her Name: _____
Employer: _____
Wk #: _____
SS #: _____
Birthday _____/_____/_____ DL #: _____

Relative or Friend not living with you

His/Her Name: _____
Wk #: _____
Hm #: _____

INSURANCE

Primary Insurance

Dental Coverage? □ Yes □ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
Insurance Co. Phone: _____
Group # (Plan, Local or Policy): _____
Insured Name: _____ Relation: _____
Insured Birthday ___/___/___ Insured ID#: _____
Insured Employer: _____
Employer's Address: _____

Secondary Insurance

Dental Coverage? □ Yes □ No
Insurance Co. Name: _____
Insurance Co. Address: _____

_____
Insurance Co. Phone: _____
Group # (Plan, Local or Policy): _____
Insured Name: _____ Relation: _____
Insured Birthday ___/___/___ Insured ID#: _____
Insured Employer: _____
Employer's Address: _____

Payment is due in full at the time of treatment.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Rho Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

CONTINUED ON THE BACK

MEDICAL HISTORY

Do you have a personal physician? □Y □N
Physician's Name: _____
Phone #: _____ Date of last visit _____
Your current physical health is: □Good □Fair □Poor
Are you currently under the care of a physician? □Y □N
Please explain: _____
Do you smoke or use tobacco in any other form □Y □N
Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath □Y □N
Have you had any metal rods, pins or implants □Y □N
Are you taking any prescription/over the counter drugs □Y □N
Please list each one: _____
Have you ever taken Fosamax, or any other bisphosphonate? □Y □N

FOR WOMEN:
Are you using a prescribed method of birth control? □Y □N
Are you pregnant? □Y □N
Are you nursing? □Y □N

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding / Hemophilia	Y N	Herpes / Fever Blisters
Y N	AIDS	Y N	High Blood Pressure
Y N	Alcohol / Drug Abuse	Y N	HIV
Y N	Anemia	Y N	Hospitalized for Any Reason
Y N	Arthritis	Y N	Kidney Problems
Y N	Artificial Bones / Joints / Valves	Y N	Liver Disease
Y N	Asthma	Y N	Low Blood Pressure
Y N	Blood Transfusion	Y N	Lupus
Y N	Cancer / Chemotherapy	Y N	Mitral Valve Prolapse
Y N	Colitis	Y N	Pacemaker
Y N	Congenital Heart Defect	Y N	Psychiatric Treatment
Y N	Diabetes	Y N	Radiation Treatment
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Emphysema	Y N	Seizures
Y N	Epilepsy	Y N	Shingles
Y N	Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Frequent Headaches	Y N	Sinus Problems
Y N	Glaucoma	Y N	Stroke
Y N	Hay Fever	Y N	Thyroid Problems
Y N	Heart Attack / Surgery	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers
Y N	Hepatitis	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following:

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry/Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs/materials that you are allergic to: _____

Why have you come to the dentist today?: _____

Are you currently in pain? □Y □N
Do you require antibiotics before dental treatment? □Y □N

Your current dental health is: □Good □Fair □Poor
Have you ever had a serious / difficult problem associated with any previous dental work? □Y □N
Do you floss daily? □Y □N Brush Daily? □Y □N
Type of bristles on your toothbrush? □ Hard □ Medium □ Soft
Have you ever had gum treatment? □Y □N
Do your gums ever bleed? □Y □N Ever Itch? □Y □N
Have you ever had periodontal disease? □Y □N
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD?) □Y □N
Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? □Y □N
Do you still have wisdom teeth? □Y □N
Would you like fresher breath? □Y □N
Would you like whiter teeth? □Y □N
Are you happy with the way your smile looks? □Y □N
If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____
Comments (if any): _____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? If yes, please explain: _____	Patient Signature Date Dentist Signature Date
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