PLEASE PRINT CLEARLY

3 Rivers Cosmetic & Restorative Dentistry

Patient's Name _____ Nickname _____ ☐ Female ☐ Male

Address _____ City _____ State _____ Zip _____

E-mail Address _____ Would you prefer E-mail over phone contact? ☐ Yes ☐ No

Home Phone _____ Cell Phone _____

Birthdate _____ S.S. # _____

Employer _____ Occupation _____

Business Address _____ City _____ Bus. Phone _____

Parent / Spouse's Name _____ S.S. # _____ Birthdate _____

Parent / Spouse's Employer _____ Occupation _____ Bus. Phone _____

INSURANCE INFO

Dental Insurance Co. _____ Group # _____

Name of Insured _____ Relationship to Patient _____

IN CASE OF EMERGENCY (Closest Relative or Friend)

Name _____ Phone _____

Physician _____ Phone _____ Pharmacy _____ Phone _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

HEALTH HISTORY

Reason for present visit. _____ Date of last dental visit. _____

Have you ever had difficulties associated with dental treatment? ☐ Yes ☐ No If yes, explain _____

Do you fear dental treatment? ☐ Yes ☐ No Are you under the care of a physician? ☐ Yes ☐ No Who? _____

Has there been any change in your general health in the last 5 years? ☐ Yes ☐ No If yes, explain _____

Date of last physical examination. _____

Are you now taking any medications? ☐ Yes ☐ No If yes, what? _____

Are you allergic to: Dental anesthetics? ☐ Yes ☐ No Penicillin or other antibiotics? ☐ Yes ☐ No
Aspirin? ☐ Yes ☐ No Latex? ☐ Yes ☐ No
Other drugs? ☐ Yes ☐ No If yes, which? _____

Have you had joint replacement? ☐ Yes ☐ No Which one? _____

Have you had heart/cardiac surgery? ☐ Yes ☐ No What type of surgery? _____

Do you use tobacco? ☐ Yes ☐ No (Women) Are you pregnant? ☐ Yes ☐ No Due Date _____

Do you have or have you had?

YES	NO		YES	NO		YES	NO	
☐	☐	Rheumatic fever	☐	☐	Heart disease	☐	☐	A stroke or circulation problems
☐	☐	High blood pressure	☐	☐	Heart valve problems	☐	☐	Heart murmur
☐	☐	Angina (chest pain upon exertion)	☐	☐	Stomach ulcers	☐	☐	Shortness of breath
☐	☐	Swelling ankles	☐	☐	Prosthetic joints	☐	☐	Allergies
☐	☐	Diabetes	☐	☐	Seizures	☐	☐	Hepatitis
☐	☐	Aids or HIV positive	☐	☐	Sinus trouble	☐	☐	Arthritis
☐	☐	Gland problems	☐	☐	Liver disease	☐	☐	Kidney problems
☐	☐	Tuberculosis	☐	☐	Glaucoma	☐	☐	Cancer or Tumors
☐	☐	Venereal disease	☐	☐	Anemia	☐	☐	Prolonged bleeding

Other medical problems not listed above.

To the best of my knowledge the provided medical and dental history is correct. I consent to such examinations, x-rays, and diagnostic procedures and tests that may be prescribed. In addition, I consent to the performing of the dental and oral surgery procedures agreed to be necessary or advisable, including the use of general or local anesthetic and indicated photos, and releasing information to my insurance company. I will assume responsibility for fees associated with any dental treatment that I or my dependent receives.

Patient's (Parent's) Signature _____ Date _____