



## Our Three Commitments to You

These commitments are put into writing because we believe that they are critical for the success of our patients in our practice. These may be different from what you have experienced in other offices, but the trust that is critical to our working together is built upon these three foundations.

### **Commitment to Treatment**

We believe that dental disease is almost completely preventable. If treatment is begun, we believe it should be completed and the work we provide must be taken care of to the best of your ability. If work is not completed the likelihood of additional complications, and extra expenses and potential tooth loss increases dramatically. These outcomes can also make communication between you and our practice more difficult. We understand that you want as little dental work done during your life as possible; that is our goal for you as well. Following through with your identified treatment needs is the best way to accomplish that goal.

### **Commitment to Appointment**

We will reserve time especially for you in our schedule. During this time we will give you our undivided attention, exceptional care and rarely keep you waiting. An appointment at our office is a bond that we will be prepared to serve you in a timely manner.

### **Commitment to Financial Considerations**

We will use our skills, professional judgment and compassionate care to help you achieve your optimum level of dental health. Following through with your financial arrangements with our office will allow us to work together with clear expectations and without resentments.

Signature \_\_\_\_\_ Date \_\_\_\_\_



## Registration Form

Please fill out accurately and completely. The confidential information requested is important for your treatment and insurance claim.

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Gender: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ (need only if used for insurance ID)

Dental Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Secondary Dental Ins. \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

### SPOUSE INFORMATION

Spouse Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employed by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Phone: Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Other information:

\_\_\_\_\_  
\_\_\_\_\_



**RIVERVIEW**  
FAMILY DENTAL  
Patient Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

Our practice is committed to providing each of our patients with individualized care consistent with their specific needs, wants and values. By answering the following questions candidly, you will help us to better understand your dental concerns and expectations. Your answers are for our records only and will remain confidential.

1. Does dental treatment make you nervous? No Slightly Moderately Extremely
2. Have you ever had any serious trouble associated with previous dentistry? Yes No
3. How often do you use the following?

Toothbrush (manual or electric) \_\_\_\_\_

Dental floss \_\_\_\_\_

Other oral hygiene device \_\_\_\_\_

4. Do you have or have you ever had any of the following?
 

Orthodontic treatment	Yes	No	Loose teeth	Yes	No
Clicking/popping jaw	Yes	No	Teeth sensitive to hot, cold, sweets	Yes	No
Difficulty opening / closing jaw	Yes	No	Teeth sensitive to chewing	Yes	No
Clenching or grinding	Yes	No	Bleeding or sore gums	Yes	No
Shifting or change in bit	Yes	No	Unpleasant taste or bad breath	Yes	No

5. The following best describes my attitude toward dental health:
  - I have always done what was recommended for my dental health.
  - I have not always done what dentists have recommended to me.
  - I rarely go to the dentist, not much interest in dental work.

6. Should I need treatment, my desire would be best described as:
  - Wanting the best restorations possible that will be the most conservative and give the longest life.
  - Wanting the least expensive restoration that will get me by for now.

7. Do you like the color of your teeth? Yes No
8. Do you consider your existing fillings or dental work as unattractive? Yes No
9. What would you like to change most in the appearance of your teeth or your smile?

10. What are some questions about dentistry and your oral health that you have never had adequately answered?

\_\_\_\_\_

\_\_\_\_\_

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Are you under a physician's care now?  Yes  No If yes

Have you ever been hospitalized or had a major operation?  Yes  No If yes

Have you ever had a serious head or neck injury?  Yes  No If yes

Are you taking any medications, pills, or drugs?  Yes  No If yes

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No If yes

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Women: Are you...

Pregnant/Trying to get pregnant?  Nursing?  Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  
 Metal  Latex  Sulfa Drugs  Local Anesthetics

Other?  If yes

Do you use controlled substances?  Yes  No If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed  Yes  No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: \_\_\_\_\_



## Financial Options

We appreciate the trust you have placed in us and would like to thank you for choosing our practice for your upcoming dental work. We believe dental treatment is one of the best investments you can make for both your physical and psychological well being. Our intention is to simplify your financial considerations and prevent them from being an obstacle to obtaining this care. We request that payment arrangements be made prior to beginning your treatment. Being sensitive to the different needs people have in fulfilling their financial obligations, we gladly provide you with several payment options.

### Payment in Full

Payment is made prior to the start of any treatment by cash, check, Visa, MasterCard, American Express or Discover by the first appointment. The one-time payment would be \$\_\_\_\_\_.

### Two Payments

For cases involving lab work, crowns, bridges, implant crowns, dentures, splints, etc. one-half may be made when the work is started (when impressions are taken) and the second-half made on or before the day the work is completed. The first half payment in the amount of \$\_\_\_\_\_, and the second half payment in the amount of \$\_\_\_\_\_ to be paid by cash, check, Visa, MasterCard, American Express or Discover.

### Custom Payment schedule

I agree to pay Riverview Family Dental the treatment fee in the following manner: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CareCredit

A credit card for health care costs, interest free payment plans up to 12 months with payments as low as \$\_\_\_\_\_. Interest retroactive at \_\_\_\_% if a payment is missed or not paid in full within the interest free period. Applications available in the office or apply online at [www.carecredit.com](http://www.carecredit.com).

Please be aware that clinical findings may require a change in treatment plan, with a possible change to your cost. The total fee is the patient's personal obligation. Please select your preferred payment option, sign below and return to us for our records.

Printed Name: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_