Riverside DENTAL CARE

• Dr. James Ott • Dr. David Stevens • Dr. Wade Stevens • Dr. Matthew Snyder • Dr. Curtis Roundy • Dr. Parker Tripp •

Patient Information

(Please print full legal name)

First Name _____ M.I._____ Last Name _____
Preferred Name _____ Gender: Male ☐ Female ☐
Date of Birth _____ Marital Status: City Single ☐ Married ☐
Home Phone _____ Cell _____ Work _____
Mailing Address _____ City _____ State _____ Zip _____
Alternative Address _____ City _____ State _____ Zip _____
Social Security Number _____ Email Address _____

Preferred Phone Number to be Contacted On
Home ☐ Cell ☐

Preferred To Be Contact By
Phone Call ☐ Text ☐

Spouse _____ Phone # _____ Date of Birth _____
Responsible Party (Other Than Patient) _____ Relationship _____ Phone # _____
Names of Family Members Who Are Patients Here _____
Who may we thank for referring you to our office? _____
Dental Insurance? Yes ☐ No ☐ **Please present insurance information prior to being seen.**
Emergency Contact Information (Required by Law)

Name _____ Name _____
Phone _____ Phone _____
Relationship to Patient _____ Relationship to Patient _____

Medical History & Allergies

Reason For First Visit With Us _____
Name of Your Former Dentist _____
Have you been told you need to PRE-MEDICATE prior to dental appointments? Yes ☐ No ☐
Are you taking any MEDICATIONS at this time? (Please list below OR supply us with a copy of a list of medications.)

_____

_____

PLEASE INFORM PROVIDER IF YOU ARE PREGNANT

Do you have history of any of the following?(Please select all that apply.)

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Alcoholism
- ☐ Cancer
- ☐ Diabetes
- ☐ Drug Abuse/Treatment
- ☐ Dry Mouth
- ☐ Emotional Problems
- ☐ Frequent Headaches
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ Herpes (Fever Blisters)
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Low Blood Pressure
- ☐ Nervous/Anxiety
- ☐ Pace Maker
- ☐ Rheumatic Fever
- ☐ Seizures/Epilepsy
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ TMJ
- ☐ Tobacco Use
- ☐ Tuberculosis
- ☐ Ulcers

Do you have allergies to any medications/other allergies? _____
Do you have any allergies to any Local Anesthetics? _____
Additional information about your health we should know about? _____

Riverside Dental Care

ACKNOWLEDGMENT AND CONSENT

Health History

_____ (Initial) I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood and completed the health history questionnaire fully and accurately to the best of my ability.

Release of Information

_____ (Initial) I understand that the dentist may need to call to collaborate with other healthcare providers and/or third-party payers in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent, during the period of dental care to third-party payers and/or other health care providers related to my care.

I agree to receive text messages from Riverside Dental Care regarding my appointment reminders and important healthcare updates. I understand that I can opt out of receiving these messages at any time by replying "STOP".

I consent to the use of photographs taken during my dental treatment for educational, promotional, or clinical purposes. I understand that these images may be used in office materials, on the practice website, or for professional presentations. I acknowledge that my identity will not be disclosed without my explicit consent.

Financial Policies

_____ (Initial) I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself and is ultimately my responsibility, not the dental office's responsibility.

I understand that I am expected to pay what is due for my treatment when I receive it. I understand that when a child of divorced parents is seen, whichever parent accompanies the child to their visit will be expected to pay. I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within 15 days of receiving this statement. A late fee of 18% of total balance or $25.00 (whichever is greater) will be applied to balances over 30 days.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency.

I understand that my account will be charged a $50.00 fee for any dishonored check and that I am expected to pick up the check and pay the balance and subsequent late fees in cash.

I understand that these policies may be superseded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling/Cancellation Policies

_____ (Initial) I understand that if I need to reschedule an appointment, or cannot make an appointment, I must give 24 hours notice to a staff member. If I do not give adequate notice, my account will be charged $25.00 cancellation fee.

I understand that if I fail or cancel more than 3 consecutive appointments without appropriate notice, my active patient status will be reduced to emergency status and I will be advised to seek and alternate dental provider.

Privacy Practices

_____ (Initial) I acknowledge receipt of Privacy Practices Notice (HIPAA) Available Upon Request.

Print patient name (or parent/guardian if minor) _____ Date _____

Signature of patient (or parent/guardian if minor) _____ Date _____