RP
RIVER PLACE DENTAL
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Date:_____

PATIENT REGISTRATION

PATIENT INFORMATION	RESPONSIBLE PARTY/GUARANTOR INFORMATION
Name:	Name:
Address:	Address:
City/State/Zip:	City/State/Zip:
Home #: Cell #:	Home #: Cell #:
Employer:	Employer:
Business Address:	Business Address:
City/State/Zip:	City/State/Zip:
Business Phone:	Business Phone:
Dental Insurance:	Dental Insurance:
Social Security #:	Social Security #:
Date of Birth:	Date of Birth:

Driver's License #:_____ Marital Status (check one): ❑ S ❑ M ❑ W ❑ D ❑ Minor Sex (check one): ❑ M ❑ F

Referred by:_____ Name(s) of the other family members who are patients of this office: _____

HEALTH HISTORY

Physician's Name & Phone:_____ Date of Last Physical Exam:_____

Preferred Pharmacy & Phone:_____

What Drugs, medication, or pills are you taking now?_____

Have you had an adverse or allergic reaction to (check one): ❑ Penicillin ❑ Novocaine ❑ Other_____

Are you presently under the care of a physician?_____ If so, for what?_____

PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

YES	NO		YES	NO		YES	NO	
❑	❑	Glaucoma	❑	❑	Cortisone Therapy	❑	❑	Heart Murmur/Prosthetic Heart Valve
❑	❑	Shortness of Breath	❑	❑	Anticoagulant Therapy	❑	❑	Hepatitis or Liver Disease
❑	❑	Swollen Arteries	❑	❑	Diabetes	❑	❑	Heart Disease
❑	❑	Thyroid Disorder	❑	❑	Stroke	❑	❑	Psychiatric Treatment
❑	❑	Sinus Problems/Hayfever	❑	❑	Radiation Therapy/Chemotherapy	❑	❑	Chest Pain/Angina
❑	❑	Anemia	❑	❑	Convulsions/Epilepsy/Seizures	❑	❑	High/Low Blood Pressure
❑	❑	Bleeding or Blood Disorders	❑	❑	TB	❑	❑	Infectious Disease or AIDS
❑	❑	Emotional Disease	❑	❑	Rheumatic Fever	❑	❑	Joint Replacement

FEMALES:

YES	NO	
❑	❑	Are you or do you suspect that you are pregnant?
❑	❑	Taking Birth Control Pill/Oral Contraception?
❑	❑	Taking Hormone Medication?

Are there any other medical conditions of which I should be made aware?

_____

_____

Do you have a history of:

YES	NO	
❑	❑	Gum Disease
❑	❑	Abscess
❑	❑	Sores (Ulcers)
❑	❑	Grinding Teeth
❑	❑	Clicking, Popping, TMJ
❑	❑	Halitosis (Bad Breath)
❑	❑	Sensitivities
❑	❑	Pain in Jaw Joint
❑	❑	Cold Sores/Fever Blisters

DENTAL HISTORY

At this moment do you have a toothache or any other pain in your head or neck? If so, please describe:

_____

Date of last dental treatment or cleaning?_____ Date of last dental X-rays?_____

What do you like best about your teeth?_____

What do you like least about your teeth?_____

What would you like to change about your mouth or teeth if you could?_____

Are there any other dental conditions or experiences of which I should be made aware?_____

_____

_____
Signature (Patient, Parent, or Guardian)

_____
Dentist's Signature

Email Address: _____