



PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MI _____ SEX: M F
BIRTH DATE: ____/____/____ AGE: ____ SS# ____ - ____ - ____ MARITAL STATUS: S M W D
ADDRESS _____ CITY _____
STATE _____ ZIP _____ HOME PHONE _____ WORK _____
CELL _____ OTHER _____ REFERRED BY _____

RESPONSIBLE PARTY / INSURANCE HOLDER INFORMATION

NAME: LAST _____ FIRST _____ MI _____ SEX: M F
BIRTH DATE: ____/____/____ AGE: ____ SS# ____ - ____ - ____ MARITAL STATUS: S M W D
ADDRESS _____ CITY _____
STATE _____ ZIP _____ HOME PHONE _____ WORK _____
CELL _____ EMPLOYER _____
NUMBER OF YEARS EMPLOYED: _____ RELATIONSHIP TO PATIENT _____
SPOUSE INFORMATION: NAME _____ EMPLOYER _____
OCCUPATION _____ SS# ____ - ____ - ____ BIRTH DATE ____/____/____
WORK PHONE _____ CELL PHONE _____

EMERGENCY CONTACT

RELATIVE NOT LIVING WITH YOU: _____ RELATIONSHIP: _____
ADDRESS _____ CITY _____ STATE _____
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DENTAL INSURANCE INFORMATION

INSURANCE CO. NAME _____ INSURANCE CO. PHONE _____
INSURANCE CO. ADDRESS _____ CITY _____
STATE _____ ZIP _____ GROUP # _____ HOLDERS NAME _____
SECONDARY INSURANCE CO. NAME _____ INSURANCE PHONE _____
INSURANCE CO. ADDRESS _____ CITY _____
STATE _____ ZIP _____ GROUP # _____ HOLDERS NAME _____

HEALTH HISTORY AND REGISTRATION

*** BOTH SIDES PLEASE ***

IT IS IMPORTANT THAT THE MEDICAL AND DENTAL INFORMATION PROVIDED IS CURRENT AND ACCURATE. FOR RIO RANCHO FAMILY DENTAL CARE TO PROVIDE SAFE AND EFFECTIVE DENTAL CARE, IT IS NECESSARY FOR THEM TO KNOW YOUR MEDICAL AND DENTAL HISTORY. THANK YOU FOR TAKING YOUR TIME TO FILL OUT THIS FORM COMPLETELY.

DENTAL HISTORY

NAME OF PREVIOUS DENTIST _____ PHONE _____

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? _____ DATE OF LAST X-RAYS _____

REASON FOR YOUR DENTAL VISIT TODAY _____

HAVE YOU HAD ANY PERIODONTAL (GUM) PROBLEMS?	YES	NO	DO YOU HAVE HEADACHES, EARACHES, OR NECK PAIN?	YES	NO	
DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER?		YES	NO	HAVE YOU WORN BRACES ON YOUR TEETH?	YES	NO
DO YOU FLOSS REGULARLY?		YES	NO	ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH?	YES	NO
ARE YOUR TEETH SENSITIVE TO (PLEASE CIRCLE)		HOT	SWEETS	IF NOT, PLEASE EXPLAIN _____		
		COLD	PRESSURE			

MEDICAL HISTORY

PHYSICIANS NAME _____ PHONE # _____

ARE YOU CURRENTLY UNDER A PHYSICIANS CARE? YES NO IF SO, FOR WHAT? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

HAVE YOU EVER TAKEN FEN-PHEN / REDUX? YES NO

DO YOU USE ANY TYPE OF TOBACCO PRODUCTS? YES NO IF SO, WHAT? _____

(FOR WOMEN ONLY) ARE YOU PREGNANT? YES NO IF NOT, ARE YOU NURSING? YES NO

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> HIV/AIDS positive | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Head injuries | <input type="checkbox"/> Pain in jaw joints | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> High Blood Pressure | | |

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING:

- | | | | |
|----------------------------------|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Penicillin | _____ |

CONSENT

THE UNDERSIGNED HEREBY AUTHORIZES RIO RANCHO FAMILY DENTAL CARE TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DR. ALLEN TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE RIO RANCHO FAMILY DENTAL CARE TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION, AND THERAPY THAT MAY BE INDICATED. I ALSO UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN MY INSURANCE CARRIER AND MYSELF, NOT BETWEEN MY INSURANCE CARRIER AND RIO RANCHO FAMILY DENTAL CARE. I AM SOLELY RESPONSIBLE FOR ALL DENTAL FEES. THESE FEES ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I

HEALTH HISTORY AND REGISTRATION

ALSO ASSIGN ALL INSURANCE BENEFITS TO RIO RANCHO FAMILY DENTAL CARE. ANY PAYMENTS RECEIVED BY RIO RANCHO FAMILY DENTAL CARE FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT. I FURTHER UNDERSTAND THAT A LATE CHARGE OR FINANCE CHARGES MAY BE ADDED TO ANY OVERDUE OR OUTSTANDING BALANCE. I UNDERSTAND THAT, WHERE APPROPRIATE, CREDIT REPORTS MAY BE OBTAINED.

PATIENT / RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____