Riverside DENTAL CARE

• Dr. James Ott • Dr. David Stevens • Dr. Wade Stevens • Dr. Scott Ellis • Dr. Matthew Snyder

Patient Information

(Please print full legal name)

First Name_____ M.I. _____ Last Name_____
Preferred Name_____ Date of Birth_____
Gender: Male ☐ Female ☐ Marital Status: Single ☐ Married ☐
Home Phone_____ Cell_____ Work_____
Mailing Address_____ City_____ State_____ Zip_____
Alternate Address_____ City_____ State_____ Zip_____
Drivers License_____ Email Address_____

Preferred Phone number to be contacted on
Home ☐ Cell ☐

Preferred to be contacted 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 PREMEDICATE prior to dental appointments? Yes ☐ No ☐
Are you taking any MEDICATIONS at this time? (please list medications 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 below)

- ☐ 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

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

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.

Financial policies

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 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

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 a $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 an alternate dental provider.

Privacy practices

_____I acknowledge receipt of Privacy Practices Notice (HIPAA) Available Upon Request
Initial

Print patient name(or parent/guardian if minor)_____Date_____

Signature of patient(or parent/guardian if minor)_____Date_____