

# Welcome to Smiles of Riverstone

Patient Information
Date _____ D.O.B. ____/____/____
ID/SS# _____
Patient _____
Address _____
City _____ State _____ Zip _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Occupation _____
Employer/School _____
Employer/School address _____
Employer/School phone _____
Spouse's Name _____
Birthdate _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

Phone Number & Email
Home _____ Work _____
Mobile _____
Email _____

Emergency Contact
In case of emergency, contact: (someone not living in your household) _____
Relationship _____
Home _____ Work _____
Mobile _____

Dental Insurance
Subscriber's name _____
Birthdate _____ SS# _____
Relationship to patient _____
Insurance Co. _____
Ins I.D. # _____
Group # _____

ASSIGNMENT AND RELEASE
------------------------

I certify that I and/or my dependents have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Jerri Vo all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to above named company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Dental History
----------------

Reason for today's visit \_\_\_\_\_

Date of last dental visit \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Please check the box to indicate if you have had any of the following:

<input type="checkbox"/> Bad Breath	<input type="checkbox"/> Chew on one side of mouth	<input type="checkbox"/> Gums swollen or tender	<input type="checkbox"/> Mouth pain, brushing
<input type="checkbox"/> Bleeding gum	<input type="checkbox"/> Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Jaw pain or tiredness	<input type="checkbox"/> Periodontal Treatment
<input type="checkbox"/> Blister on lips or mouth	<input type="checkbox"/> Clicking or popping jaw	<input type="checkbox"/> Lip or cheek biting	<input type="checkbox"/> Sensitivity to cold
<input type="checkbox"/> Burning sensation on tongue	<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Loose teeth or broken fillings	<input type="checkbox"/> Sensitivity to heat
<input type="checkbox"/> Grinding teeth		<input type="checkbox"/> Sensitivity to sweets	

How often do you floss \_\_\_\_\_ How often do you brush? \_\_\_\_\_

Health History
----------------

Blood pressure \_\_\_\_\_

Name of Physician \_\_\_\_\_ Physician Phone \_\_\_\_\_

When was the last time you saw your physician? \_\_\_\_\_

Please state the reason of your last medical visit \_\_\_\_\_

Are you now under the care of a physician?  Yes  No If yes, please explain. \_\_\_\_\_

**(Health History con't on back)**