PATIENT REGISTRATION

First Name: _____ Last Name: _____ Middle Initial: ____

Preferred Name: _____

Patient Is: ☐ Policy Holder

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Seperated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ ☐ I would like to receive correspondances via email.

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Emergency Contact Person: _____ Phone: _____

Other Family Members Seen By Us: _____

Whom May We Thank For Referring You: _____

Additional Comments:

Primary Insurance Information

Name Of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____

Secondary Insurance Information

Name Of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Subscriber ID#: _____ Group #: _____ Ins. Phone #: _____

Riversbend Dental Springdale

wwwriversbendspringdale.com
315 West Kemper Road • Cincinnati, OH 45246 (513)772-8840

Health History (confidential)

Name: _____

Date of Birth: _____ **Today's date:** _____

Primary care doctor (skip if you do not have a doctor):

_____

_____

Date of last physical exam: _____

Medications list (including non-prescriptions, vitamins, and supplements):

_____

_____

_____

_____

Do you currently take or have you ever taken a bisphosphonate or other medication for osteoporosis (i.e. Fosamax, Boniva, Actonel, Prolia)? If yes, please list medication name and when taken:

_____

_____

Have you ever had any type of cancer? If so, please list treatment type and when:

_____

_____

Please indicate if you have any of the following conditions that may impact dental treatment:

Allergies (seasonal) / Sinus ◯ Yes ◯ No

AIDS / HIV Infection ◯ Yes ◯ No

Anemia ◯ Yes ◯ No

Angina (chest pain) ◯ Yes ◯ No

Anxiety / Nervousness ◯ Yes ◯ No

Artifical Heart Valve ◯ Yes ◯ No

Arthritis ◯ Yes ◯ No

Asthma ◯ Yes ◯ No

Bypass Surgery ◯ Yes ◯ No

Blood Disorders ◯ Yes ◯ No

Canker Sores ◯ Yes ◯ No

Cardiac Pacemaker ◯ Yes ◯ No

Cold Sores (fever blisters) ◯ Yes ◯ No

Congenital Heart Defect ◯ Yes ◯ No

Congestive Heart Failure ◯ Yes ◯ No

Diabetes I or II ◯ Yes ◯ No

If diabetic, most recent A1C: _____

Epilepsy / Seizures ◯ Yes ◯ No

Fainting / Dizziness ◯ Yes ◯ No

Glaucoma ◯ Yes ◯ No

Heart Murmur ◯ Yes ◯ No

Heart Disease / Heart Attack ◯ Yes ◯ No

Hepatitis A, B, or C ◯ Yes ◯ No

High Blood Pressure or Low Blood Pressure ◯ Yes ◯ No

If high or low blood pressure, last BP reading: _____

High Cholesterol ◯ Yes ◯ No

Irregular Heartbeat ◯ Yes ◯ No

Joint Replacement ◯ Yes ◯ No

Kidney Disease ◯ Yes ◯ No

Kidney Infection / Stones ◯ Yes ◯ No

Liver Disease / Jaundice ◯ Yes ◯ No

Mitral Valve Prolapse ◯ Yes ◯ No

Radiation / Chemotherapy ◯ Yes ◯ No

Respiratory Problems (i.e. Emphysema or COPD) ◯ Yes ◯ No

Rheumatic Fever / Heart Disease ◯ Yes ◯ No

Sleep apnea ◯ Yes ◯ No

Stomach / Bowel / GI Disease ◯ Yes ◯ No

Stroke ◯ Yes ◯ No

Thyroid Disorder ◯ Yes ◯ No

Tuberculosis ◯ Yes ◯ No

Ulcers ◯ Yes ◯ No

Any conditions not listed above:

_____

_____

Are you allergic to or unable to take any of the following:

Acetaminophen (Tylenol) ◯ Yes ◯ No

Local Anesthetic ◯ Yes ◯ No

Amoxicillin / Penicillin ◯ Yes ◯ No

Aspirin ◯ Yes ◯ No

Azithromycin / Clarithromycin / Erythromycin ◯ Yes ◯ No

Cephalosporin (Keflex) ◯ Yes ◯ No

Clindamycin ◯ Yes ◯ No

Codeine ◯ Yes ◯ No

Ibuprofen (Advil, Motrin) ◯ Yes ◯ No

Latex ◯ Yes ◯ No

Narcotic pain medication ◯ Yes ◯ No

Tetracycline ◯ Yes ◯ No

Other:

_____

_____

Have you been hospitalized for any surgical procedures or serious illnesses within the last 5 years? ◯ Yes ◯ No

If yes, please explain

_____

_____

Do you bruise easily or have prolonged bleeding? ◯ Yes ◯ No

Have you had any recent major weight loss? ◯ Yes ◯ No

Have you ever taken Fen-Phen for weight loss? ◯ Yes ◯ No

Have you ever required a blood transfusion? ◯ Yes ◯ No

Do you use tobacco products? ◯ Yes ◯ No

Does your physician require you to take an antibiotic prior to dental visits? ◯ Yes ◯ No

Please skip to signature if following questions are not applicable

Are you:

☐ pregnant or think you may be ☐ nursing ☐ taking any form of birth control

Signature _____ **Date** _____

Response Date: _____

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Dental History (confidential)

Name: _____

Date of Birth: _____ **Today's Date:** _____

Reason for today's visit (i.e. general checkup or more specific concern):

_____

_____

Name of Previous Dentist and Location: _____

When was your last dental cleaning and exam? _____

When did you last have xrays taken? _____

When was your last dental visit other than a cleaning? What treatment was performed? (please write N/A if not applicable)

_____

_____

Are you satisfied with the appearance of your smile? ◯ Yes ◯ No

If no, what specifically would you change?

_____

_____

Do you have any type of anxiety with regard to dental treatment? ◯ Yes ◯ No

If yes, what do you dislike most about dental treatment?

_____

_____

Please indicate if you have had any of the following:

Gum treatments or gum surgery ◯ Yes ◯ No

Oral surgery/wisdom teeth removed ◯ Yes ◯ No

Orthodontic treatment (i.e. braces) ◯ Yes ◯ No

Bite adjustments/equilibration ◯ Yes ◯ No

Nitrous oxide (laughing gas) ◯ Yes ◯ No

Do you wear dentures or partials or another removable prosthesis? ◯ Yes ◯ No

If yes, please indicate approximately how old they are: _____

Signature _____ **Date** _____

Response Date: _____

Patient consent HIPAA Acknowledgement/Release

I understand that, under the Health Insurance Portability & Accountability Act of 2012 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct a plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have the right to read the *Notice of Privacy Practices* before deciding whether to sign this consent.

This office reserves the right to change the pricey practices as described in the Notice of Privacy Practices. If it is changed, a revised Notice of Privacy Practices will be issued.

I have the right to request you place additional restrictions on the use or disclosure of my health information. You are not required to agree to these additional restrictions, but if you do, you will abide by our agreement (except in an emergency).

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action on your consent.

Patient Name: _____ DOB: _____ agree to release any personal information to the following:

Name(s)

_____

_____

_____

_____ _____

Signature of patient (or responsible party) Date

EXPERIENCED, STATE OF THE ART DENTISTRY

Riversbend Dental
SPRINGDALE

Appointment Policy

Our staff at Riversbend Dental Springdale is committed to providing the highest quality of dental care and services for our patients. Dental procedures require preparation and planning. This includes appropriate staffing, treatment room availability and material preparation at specific times during our workday. We reserve specific time blocks to meet patient schedules and the urgency of dental need. If you have made an appointment with us, that time has been reserved exclusively for you and we have prepared in advance for your visit. Please be advised the following requirements:

- We require 48 hours' notice for cancellation of a scheduled appointment.
- A minimum cancellation fee of $50 will be added for all missed or cancelled appointments with less than 48 hours' notice. Appointments longer than 60 minutes will result in a higher fee.
- Appointments missed or cancellation with less than 48 hours' notice, during/around a holiday or during peak hours (8am – 10am – 3pm-5pm) will be subject to a charge and we reserve the right to decline future appointments during peak dates/hours.
- If there are three missed or cancelled appointments without 48 hours' notice within a 1-year time frame, we reserve the right to not schedule any further appointments or to require a deposit to schedule a future appointment.
- Family/medical emergencies will be taken into consideration.
- Failure to comply with any subsequent appointments needing to complete treatment (such as a crown or appliance seat) will not affect the amount due for billed treatment.

_____ _____

Signature of patient (or responsible party) Date

EXPERIENCED, STATE OF THE ART DENTISTRY

Riversbend Dental
SPRINGDALE

Financial Consent

The patient (or person with financial responsibility for the account) agrees to be fully responsible for total payment of treatment performed in this office.

I authorize Riversbend Dental Springdale to leave messages regarding my account, including but not limited to, any balance due on the following # _____

Names of patients that are responsibility of the signer (please print):

_____

_____

_____

_____ _____

Signature of patient (or responsible party) Date

EXPERIENCED, STATE OF THE ART DENTISTRY

Riversbend Dental
SPRINGDALE

Insurance

Riversbend Dental Springdale is committed to helping our patients maximize their dental benefits. As you may be aware, medical and dental insurances are becoming increasingly complex. We are always available to answer your questions, however, your insurance policy is a contract between you and your insurance company.

As a medical provider, we are not party to that agreement. The patient portion (co-payment) for your bill must be paid at the time of service. We ask our patients to provide us with complete dental insurance information. As a service to our patients, we will bill insurance companies for services and allow 45 days to render payment in full. After 60 days, you are responsible for the entire balance which is due in full upon request.

Insurance policies vary considerably; therefore, we estimate your coverage in good faith but cannot guarantee coverage or payment amounts by your insurance company. Riversbend Dental Springdale can only provide estimates and not exact amounts.

If you have any questions, please do not hesitate to contact our office at 513.772.8840

We look forward to seeing you!

You're Riversbend Dental Springdale Team.

EXPERIENCED, STATE OF THE ART DENTISTRY

Riversbend Dental
SPRINGDALE

Record Release Request

Date: _____

Previous Dental Office: _____

Address: _____

City: _____ State: _____ Zip: _____

I request and authorize the release of dental records and x-rays to dental treatment, or copies of such, and request they be transferred to: office@riversbendspringdale.com, if unable to transfer records via email please mail to the address below.

Patient's name:_____

Date of Birth: _____

Signature: _____

If patient is a minor, relationship to patient: _____

315 West Kemper Road Cincinnati, Ohio 45246 513.772.8840