Rio Rancho
Family Dental Care

HEALTH HISTORY AND REGISTRATION

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 _____ Email_____**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_____

*** 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 COLD	SWEETS PRESSURE	IF NOT, PLEASE EXPLAIN_____		

MEDICAL HISTORY

PHYSICIANS NAME_____ PHONE #_____

ARE YOU CURRENTLY UNDER A PHYSCIANS 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:

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

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

- ❑ Aspirin
- ❑ Latex
- ❑ Codeine
- ❑ Sulfa
- ❑ Local Anesthetic
- ❑ Nitrous Oxide
- ❑ Ibuprofen
- ❑ Erythromycin
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other_____
_____

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 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:_____