RIO MIMBRES FAMILY DENTAL

Patient Name: _____ Preferred Name: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
DOB: _____ SSN: _____ Gender: Female Male

Marital Status: Married Divorced Single Domestic Partner Child Widow
Home Phone: _____ Cell Phone: _____
Email address: _____@_____

Whom may we thank for referring you to our Practice? _____

Primary Insured

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____ State: _____Zip: _____
Relationship to Patient _____ Employer: _____ Work Phone: _____
Dental Insurance Company: _____ ID Number: _____

Federal Employees

Federal Employee Medical Insurance: BCBS ID: R_____ GEHA ID # _____

Secondary Insured

Name: _____ DOB: _____ SSN: _____
Address: _____ City: _____ State: _____Zip: _____
Relationship to Patient _____ Employer: _____ Work Phone: _____
Dental Insurance Company: _____ ID Number: _____

Responsible Party

<u>This must be filled out please.</u>

Name: _____ Relationship to Patient: _____
Mailing Address: _____ City: _____ State: _____Zip: _____
DOB: _____ SSN: _____ Daytime Phone: _____

Insurance Policy and Financial Agreement

I hereby authorize Rio Mimbres Family Dental to furnish information to my dental carrier concerning my treatment and I hereby assign to the doctors all payments for dental treatment rendered to myself or my dependents.

Your Insurance Contract is an agreement between you and your insurance company. We are not a party to that contract. Your complete insurance information must be presented at the time services are provided. All insurance co-pays, co-insurance and deductibles must be paid at the time of service. The responsible party is responsible for any unpaid charges due to exclusions and limitations written in per your plan provisions or all uninsured costs.

Signed: _____ Date: _____

Patient Medical History

Do you have or have you had any of the following? Please Circle Y for yes and N for no

Y N Arthritis
Y N Asthma
Y N Heart Murmur / MVP
Y N Heart Disease
Y N Congenital Heart Lesions
Y N Stent / Pacemaker
Y N Prolonged Bleeding Disorder
Y N Auto Immune Disorder
Y N Tumor/Malignancy
Y N Radiation / Chemo Therapy
Y N High/Low Blood Pressure
Y N Anemia
Y N HIV/AIDS
Y N STD/Herpes
Y N Hepatitis Type _____
Y N Jaundice
Y N TB or Lung Disease
Y N Kidney Disease
Y N Stroke
Y N Artificial Joints: Where: _____
Y N Hearing Loss
Y N Fainting Spells
Y N Depression
Y N Pregnant/Nursing
Y N Ulcers
Y N Glaucoma
Y N Diabetes

Y N Smoke or smokeless tobacco _____ per day How many years? _____ Have you quit Y N When? _____
Y N Substance Abuse What? _____ How often? _____ Have you quit? Y N When? _____
Y N Do you take Fosamax, Boniva, Actonel, Aredia, Zometa, etc. for Osteoporosis or any other condition? Y N
Y N Had major surgery? Year _____ Type _____
Year _____ Type _____
Year _____ Type _____

Are you allergic to any of the following (please circle)
Aspirin Ibuprofen Sulfa Drugs Penicillin Codeine Latex Local Anesthetics
Other allergies to medications _____ _____ _____

Please List the medications you are currently taking with dosage and for what condition
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____
Rx: _____ Condition _____ How often? _____

Patient Dental History

Last Dental Exam _____ Last Cleaning _____
How often do you brush? _____ Floss _____

(please circle)

Y N I prefer tooth colored fillings
Y N Gums feel tender or swollen
Y N I have had oral surgery
Y N I clench or grind my teeth during the day or while sleeping
n Y N Gums bleed while brushing or flossing
Y N Would you like to change anything about your smile? What? _____
What are your dental priorities? _____
(e.g.: appearance, dental health, etc.)

Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the providers at Rio Mimbres Family Dental to perform any necessary dental services, with my informed consent, that may be needed during diagnosis and treatment.

Signed: _____ Date: _____

NEW PATIENT CALL FORM

Patient Name _____ DOB _____ Todays Date _____
Parent or Guardian _____ How did you hear about us? _____
Daytime phone _____ Cell phone _____
Email address _____@_____._____ Send NP Packet Y N mail email (circle)

Preferred appointment day _____ AM or PM

NP Adult EX, PX, BWX
Last Dental Visit? _____ Were x-rays taken? Y N How long ago? _____
Are you currently having a problem? Y N Where? _____
Premed prior to dental appointment Y N for what reason. _____

NP Emergency Patient LE, PA
Swelling Y N Hot or cold sensitive Y N Is the tooth broken Y N Right or Left Upper or Lower
Are you currently taking antibiotic? Y N How long has this been hurting? _____

NP Pedo Patient CPx, EX, BWX, FlTx
Last Dental Visit? _____ Were x-rays taken? Y N How long ago? _____
Has patient been hospitalized for dental Tx in the past? Y N When? _____ Where? _____
Currently having a problem? Y N Where? _____ Previous Dentist _____

NP Extraction referral LE
Swelling Y N Currently taking antibiotic? Y N Did your dentist give you an x-ray Y N Pano or PA
Patient requesting IV Sedation Y N Referring Dentist _____

INSURANCE INFORMATION

Primary Insured _____ DOB _____
SSN/ID _____ Employer _____
Insurance Company _____ Federal Employee Y N

OFFICE USE:

Record release form sent to patient via: Mail Email Fax *Pt does not want to contact previous dentist

Appointment Date _____ Time _____ Employee Initials _____

Notes
_____
_____
_____