Riverdale Family Dental
CONFIDENTIAL
New Patient Forms

Date: ____________

Name: ____ Birthdate: ___________
Address: ____
City: ______________________State: ____________ Zip Code: _________________

Reason for today's visit: ____

Check Appropriate Box:

☐ Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Cell Phone: _________________________ Home Phone: ____________________
Is it okay to text you? YES____ ↔ NO_____

Email: ____

Emergency Contact Information:

Name: _________________ Cell Phone__________________ Relation: _________

Whom may we thank for referring you?
____

Insurance Information:

Subscriber Name: ________________________________
Subscriber Birthdate: _____________________________
Relationship to Subscriber: ________________________
Insurance Company: _______________________________
Group Number: ___________________________________
Policy/ID Number: ________________________________
Social Security Number: ___________________________
Do you have a secondary insurance: _________________

X___________________________________ Date: ________________________
Patient, Parent or Guardian signature

RIVERDALE
FAMILY DENTAL

Patient Medical History:

Physician's Name: ____________________________
Office Phone: _________________________________
Date of Last Exam: ____________________________
Have you had any surgeries, serious illness, or hospitalization recently? ☐YES ☐NO
Please Describe (only if your answer was yes):

____

	Yes	No
1. Do you use tobacco	☐	☐
2. Do you use alcohol, cocaine, or other drugs?	☐	☐
3. Are you wearing contact lenses?	☐	☐

WOMEN ONLY

	Yes	No
A. Are you pregnant or think you may be pregnant?	☐	☐
1. If you answered YES to the last question, how many months are you? ________________________		
B. Are you nursing?	☐	☐
C. Are you taking birth control pills?	☐	☐

Allergies:

Please indicate if you are allergic to or have had any reactions to any drugs? Which of the following applies to you, check only if the answer is YES.

☐ Acetaminophen/Tylenol	☐ Acrylic	☐ Amoxicillin
☐ Aspirin	☐ Barbiturates	☐ Clindamycin
☐ Codeine	☐ Erythro	☐ General Anesthetics
☐ Ibuprofen/Motrin/Advil	☐ Iodine	☐ Latex
☐ Local Anesthetics	☐ Metal	☐ Novocain
☐ Penicillin	☐ Sedatives	☐ Sulfa

RIVERDALE FAMILY DENTAL

☐ No Allergies

Medical Conditions:

Please indicate which of the following applies to you, check all that applies.

☐ AIDS/HIV	☐ Alzheimer's	☐ Anaphylaxis
☐ Anemia	☐ Angina	☐ Anxiety
☐ Any Immune Deficiency	☐ Any Type of Implant	☐ Any Type of Transplant
☐ Arthritis	☐ Artificial Heart Valves	☐ Artificial Joints
☐ Asthma	☐ Back Problems	☐ Bad Breath
☐ Bleeding Gums	☐ Blood Disease	☐ Blood Transfusion
☐ Breathing Problems	☐ Bruise Easily	☐ Bulimia

☐ Cancer	☐ cardiovascular disease	☐ Chest Pain
☐ Circulatory Problems	☐ Clicking in Jaw	☐ Congenital Heart Disorder
☐ Convulsions	☐ Currently Nursing	☐ Currently Pregnant
☐ Depression	☐ Diabetes	☐ Difficulty in Chewing
☐ Difficulty in Opening Jaw	☐ Drug Addiction	☐ Ear Aches
☐ Easily Winded	☐ Emphysema	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting or Dizzy Spells
☐ Fingernail Biting	☐ Frequent Cough	☐ Frequent Diarrhea
☐ Frequent Headaches	☐ Frequently Tired	☐ G.E. Reflux/Persistent Heartburn
☐ Gastrointestinal Disease	☐ Genital Herpes	☐ Glaucoma
☐ Hay Fever	☐ Head/Neck Injury	☐ Headaches
☐ Heart Attack/Failure	☐ heart disease	☐ Heart Murmur
☐ Heart Rhythm Disorder	☐ Heart Surgery	☐ Heart Trouble
☐ Hemophilia	☐ Hepatitis	☐ Hepatitis A
☐ Hepatitis B	☐ Hepatitis C	☐ Herpes
☐ High Blood Pressure	☐ High Cholesterol	☐ Hives or Rash
☐ HPV	☐ Hypoglycemia	☐ Irregular Heartbeat
☐ Jaundice	☐ kidney disease	☐ Leukemia
☐ Lip or Cheek Biting	☐ Liver Disease	☐ Loose Teeth or Broken Fillings
☐ Low Blood Pressure	☐ lung disease	☐ Mitral Valve Prolapse
☐ Mouth Sores/Growths	☐ Neurological Disorders	☐ Osteopenia
☐ Osteoporosis	☐ Pacemaker	☐ Pain Around Ear
☐ Pain in Your Jaw (TMJ)	☐ Parathyroid Disease	☐ Periodontal Disease
☐ Recent Weight Loss	☐ Recurrent Infections	☐ Renal Dialysis
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism
☐ Scarlet Fever	☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Sleep Apnea	☐ Slow Healing Wounds
☐ Special Diet	☐ Spina Bifida	☐ Stomach Problems
☐ Stroke	☐ Swelling of Limbs	☐ Teeth Grinding/Clenching
☐ Thyroid Disease	☐ Tonsillitis	☐ Tooth Pain
☐ Tooth Sensitivity to Cold or Hot	☐ Tooth Sensitivity to Sour	☐ Tooth Sensitivity to Sweets
☐ Tooth Sensitivity when Biting	☐ Tuberculosis (TB)	☐ Tumors or Growths
☐ Ulcers	☐ Use of Controlled Substances	☐ Use of Tobacco Products
☐ Venereal Disease	☐ Wearing Contact Lenses	☐Other

☐ No Medical Condition

RIVERDALE FAMILY DENTAL

Medical Treatment:

Please indicate which of the following applies to you, check all that applies.

☐ Chemotherapy	☐ Psychiatric Treatment	☐ Radiation Treatment

☐ Not Receiving Any Treatments

Medication:

Please indicate which of the following applies to you, check all that applies.

☐ Any Bisphosphonates	☐ Actonel	☐ Boniva
☐ Cortisone Medicine	☐ Fosamax	☐ Oral Contraceptives
☐ Test Medication	☐ Reclast	☐ Other

☐ No *Medications*

Any comments or concerns you would like to let the doctor or receptionist know before your visit:

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RIVERDALE
FAMILY DENTAL