RIVER RUN DENTAL

PATIENT REGISTRATION

PATIENT INFORMATION

*Patient Name:*____
Last *First* *Middle*

*Address:*____
Street *City* *Zip Code*

*Phone:*______________________________ *Email:*______________________
Home *Work/Cell*

*How did you hear about River Run Dental?*______________________________

If you found us online, what led you to our website? ______________________

*SS#:*__________________ *DOB:*________________ *Gender: (circle)* *Male* *Female*

*Employer:*____________________ *If Student, Name of School:*________________

*If Minor, name of Parent/Guardian:*______________________________

*Employer of Parent/Guardian:*______________________________

*Address of Parent/Guardian(if different):*______________________________

*Emergency Contact:*____
Name *Phone Number* *Relationship to Patient*

MEDICAL HISTORY

☐Anesthesia Allergy	☐Asthma	☐Heart Disease	☐Sinus Problems
☐Codeine Allergy	☐Arthritis	☐Heart Murmur	☐Skeletal Implants
☐Latex Allergy	☐Blood Disease	☐Hepatitis / Jaundice	☐Stomach Problems
☐Metal Allergy	☐Dizziness	☐Smoker	☐Stroke
☐Penicillin Allergy	☐Cancer	☐High Blood Pressure	☐Tuberculosis
☐Tetracycline Allergy	☐Diabetes	☐Kidney Disease	☐Tumors
☐Peanut Allergy	☐Drug Treatment	☐Mental Disorder	☐Venereal Disease
☐Allergies, Other__________	☐Epilepsy	☐Mitral Valve Prolapse	
☐AIDS/HIV	☐Excessive Bleeding	☐Nervous Disorder	Women Only:
☐Alcohol Treatment	☐Fainting	☐Pacemaker	Pregnant Y N
☐Anemia	☐Glaucoma	☐Radiation Treatment	If so, Due Date:___________
	☐Hay Fever	☐Respiratory Problems	Nursing Y N
	☐Head Injuries	☐Rheumatic Fever	Taking Oral Contraceptives:
			Y N

Have you ever been admitted to the hospital or undergone surgery in the past 2 years? YES NO

*If Yes, Please Explain:*____

Are you under the care of a Physician aside from your primary care physician? YES NO

Have you had steroids in the last 2 years? YES NO

Do you consider yourself to be in good health? YES NO

Are you currently taking any medication? *If Yes, Please List:*____

*Do you have any health problems that need further clarification?*____________________________________

All of the following are important to us. We would like to know which is the most important to you.

- ☐ *Function - how you bite, chew and speak*
- ☐ *Comfort - addressing current pain and staying out of future pain*
- ☐ *Cosmetic - the appearance of your teeth and smile*
- ☐ *Longevity - preserving your teeth / maintaing optimal dental health*

When considering having treatment done, which of these would be of concern to you?
(please check all that apply)

- ☐ *Fear*
- ☐ *Time*
- ☐ *Budget*
- ☐ *Trust*
- ☐ *No sense of urgency*

*What is the most important quality for you in a relationship with a doctor?*____________________________________

Are you the type of person who like a lot of detailed information or do you prefer more bottom line information?

- ☐ *I prefer detailed information*
- ☐ *I prefer bottom line information*

What is your preferred contact method?

- ☐ *Home Phone*
- ☐ *Cell Phone*
- ☐ *E-Mail*
- ☐ *Text Message*

AUTHORIZATION & RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information may be hazardous or dangerous to my health.

X____ ______________________

Signature *Date*