RIVERSIDE
DENTAL

HOUSEHOLD INFORMATION

Responsible Party:		Birthday:
Mailing Address:	Physical Address:	
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:
Email:	Would you like to receive appointment reminders via: ☐ Text ☐ Email	

FAMILY INFORMATION (Please list all members of your family you would like on your account.)

Spouse:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐
Child:	Birthday:	M ☐ F ☐

INSURANCE INFORMATION (Make sure we make a copy of your primary and secondary insurance cards)

Subscriber's Name:	
Social Security Number:	Subscriber's Birthday:
Employer:	

REFERRAL INFORMATION (What brought you to visit us?)

☐ Person:	☐ Internet	☐ Newspaper	☐ Phone Book	☐ Other

WARRANTY: We guarantee all of our work and will replace anything resulting from technique or material error at no cost to you if you maintain regular 6 month maintenance visits and complete all necessary work. Not doing these things will jeopardize the success of the work we perform. We feel confidant offering this guarantee because we use the best materials and techniques available.

PRIVACY POLICY: We are committed to keeping all of your information private and will not discuss or share personal information except with those authorized by you. We shred and properly dispose of all documents that have any personal information on them. Your email is kept private. We fully comply with all provisions of HIPAA. Sign below to verify you have received a copy of our Notice of Privacy Practices.

CONSENT TO PROCEDURES: You authorize the doctors and/or the staff at Riverside Dental to perform those procedures agreed upon and within the standard of care on you (or at your request, to your minor child or ward). We commit to informing you about all procedures. We encourage you to diligently ask us if you have any questions about any procedures or their necessity, for we want you completely comfortable through the entire process.

PAYMENT POLICY:

- You agree to be responsible for your own dental bill. We will do our best to help bill your insurance, but you are responsible if they do not cover services performed.
- All copayments (or entire fee for patients without insurance) are due at time of service.
- We accept cash, credit cards, and checks.
- We offer care credit with 6 or 12 months 0% interest plans.
- You agree to pay any late fees assessed if your account becomes past due, interest charges, and agree to pay a 35% collection fee on any unpaid balance along with all attorney's fees and court costs if your account must be turned over to collections.

Responsible Party Signature:	Date:

Time 3:06 PM

Mark W. Johnson, DMD

Date 6/27/2022

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____