DANIEL A RIVERA DDS

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1. ABOUT THE PATIENT

Name _____Birthdate _____ ☐ Male ☐ Female
First M.I. Last
Nickname _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
Residence Address _____
Street City State Zip
Mailing Address (if different from above) _____
Primary Phone #: _____ Cell _____ Work Phone #: _____ Ext. _____
Email: _____ Contact preference: ____Home ____Cell ____Email
Social Security #: _____-_____-_____ Driver's License #: _____
Employer _____
Employer Address _____
Is the patient a dependent? ☐ Yes ☐ No (if yes, please fill out section 2)
Is the patient a full-time student? ☐ Yes ☐ No Name of School: _____
Who may we thank for referring you to our office? _____

2. GUARANTOR/PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Billing Address: _____
Employer Address: _____
Primary Phone #: _____ Best time to call: AM PM
Second Phone #: _____ D.O.B.: _____
SS#: _____-_____-_____ DL#: _____

3. EMERGENCY CONTACT

In the event of an emergency, we may need to contact a relative or someone who lives near you other than immediate family.
Name _____
Address _____
Relationship to Patient _____
Day Phone (____) _____
Evening Phone (____) _____

4. DENTAL INSURANCE

PRIMARY DENTAL INSURANCE
Insured's Name _____Relation _____
SS #: _____ Birthdate _____
Insured Employer _____
Employer Address _____
Insurance Co. Name _____
Group # (Plan, Local or Policy #) _____

SECONDARY INSURANCE
Insured's Name _____ Relation _____
SS #: _____ Birthdate _____
Insured Employer _____
Employer Address _____
Insurance Co. Name _____
Group # (Plan, Local or Policy #) _____

THIS OFFICE RESERVES THE RIGHT TO VERIFY THE CREDIT STATUS OF POTENTIAL PATIENTS AND/OR PARENTS OF PATIENTS PRIOR TO EXTENDING CREDIT FOR TREATMENT FEES, AND MAY, AT THE DISCRETION OF THE OFFICE, USE THE SERVICES OF ONE OR MORE CREDIT REPORTING SERVICES. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DANIEL A RIVERA DDS, INC. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

I UNDERSTAND THAT THIS PRACTICE PROVIDES SPACE, EQUIPMENT, SUPPORT PERSONNEL AND ADMINISTRATIVE SERVICES TO FACILITATE EACH DENTIST TO FOCUS ON PATIENT CARE. THE INDIVIDUAL DENTISTS PRACTICING AT THIS PRACTICE ARE NOT AGENTS OR EMPLOYEES OF THIS PRACTICE. EACH OF THEM EXERCISES INDEPENDENT PROFESSIONAL JUDGMENT IN THE NATURE AND MANNER OF DENTAL CARE AND TREATMENT PROVIDED. I ACKNOWLEDGE THAT I AM AWARE THAT ALL OF THE DENTIST(S) ARE NOT EMPLOYEE AGENTS OF THIS DENTAL OFFICE.

My signature acknowledges receipt of the Dental Materials Fact Sheet (DMFS) and the notice of Privacy Practices (HIPPA).

Signature of Patient/Parent or Legal Guardian _____ Date _____

5. DENTAL HISTORY

Are there any dental concerns that you would like your dentist(s) to review with you? Please explain: _____

_____

Your current dental health is: ☐ Good ☐ Fair ☐ Poor Approximate date of your last dental visit: _____

How many times a week do you floss? _____ How many times a day do you brush? _____

Type of bristles: ☐ Hard ☐ Medium ☐ Soft

Any apprehension or unfavorable experiences in a dental office? Yes No

Have you ever experienced TMJ problems? Yes No

(TMJ is pain or discomfort in your jaw joints)

Are you under any unusual stress at home or work? Yes No

Do you grind your teeth? Yes No

Would you like to prevent the need for dentures? Yes No

Do your gums bleed? Yes No

Do you like your smile? Yes No

6. MEDICAL HISTORY

1. Your current physical health is: ☐ Good ☐ Fair ☐ Poor
2. Are you currently under the care of a physician? Yes No
3. Any serious medical problems in the last 5 years? Yes No
   a. If so, please explain: _____
4. Are you taking prescription(s)/over the counter drugs?
   a. Antibiotics or sulfa drugs? Yes No
      1. Do you take pre-medication before dental treatment? Yes No
         a. If so, please explain: _____
         b. Anticoagulants (blood thinners)? Yes No
         c. Aspirin? Yes No
         d. Cortisone (steroids)? Yes No
         e. Digitalis or drugs for heart trouble? Yes No
         f. High blood pressure medications? Yes No
         g. Insulin, Tolbutamide (Orinase) or similar drug? Yes No
         h. "OSTEOPOROSIS DRUG" now or within in the last 5 years: Yes No
            Actonel, Boniva, Didronel, Fosamax, Bonefos, Zometa, etc.?
         i. Tranquilizers? Yes No
         j. Other: Yes No
5. Are you ALLERGIC or have you REACTED ADVERSELY to:
   a. Aspirin? Yes No
   b. Barbiturates, sedatives or sleeping pills? Yes No
   c. Iodine? Yes No
   d. Latex? Yes No
   e. Local Anesthetics? Yes No
   f. Penicillin or other antibiotics? Yes No
   g. Sulfa drugs? Yes No
   h. Other: Yes No
6. Do you have a respiratory illness? Yes No
7. Have you had a cough for at least 3 weeks not explained by a noninfectious condition? Yes No
8. Have you had a coughing fit that interferes with eating, drinking, talking or breathing? Yes No
9. In addition to coughing, are you currently experiencing or recently experienced:
   - Unexplained weight loss (more than 5 pounds)? Yes No
   - Night sweats? Yes No
   - Fever? Yes No
   - Chronic fatigue or malaise? Yes No
   - Coughing up blood? Yes No
   - Painful, swollen salivary glands? Yes No
   - Unexplained rash? Yes No
   - Stiff neck? Yes No

- Asthma, allergies or hay fever? Yes No
- Arthritis? Yes No
- Fainting spells or seizures? Yes No
- Hepatitis, jaundice or liver disease? Yes No
- HIV or AIDS? Yes No
- Hives or skin rash? Yes No
- Inflammatory Rheumatism (painful, swollen joints? Yes No
- Kidney trouble? Yes No
- Rheumatic fever or rheumatic heart disease? Yes No
- Stomach ulcers? Yes No
- Venereal Disease? Yes No

10. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No
    a. Do you bruise easily? Yes No
    b. Have you ever had a blood transfusion? Yes No
    If so, please explain -_____
11. Do you have any blood disorder(s) such as anemia? Yes No
12. Have you had surgery or x-ray treatment for a tumor, cancer, growth or other condition of your mouth or lips? Yes No
13. Do you have any implants and/or prosthesis (i.e. knee joints, elbow pins, dental implants, etc.)? Yes No
    If so, please explain: _____
    Date of surgery: _____
14. Do you have, have been expose to, or had any of the following:
    a. Cardiovascular Disease: heart trouble, heart attack, high or low blood pressure, Coronary insufficiency, coronary occlusion, arteriosclerosis or stroke? Yes No
    b. Do you have pain in your chest upon exertion? Yes No
    c. Are you ever short of breath after mild exercise or when you lie down? Yes No
    d. Do your ankles swell? Yes No
    e. Mitral valve prolapse? Yes No
    f. Heart murmur? Yes No
    g. Congenital Heart Lesions? Yes No
15. Diabetes? Yes No
    - Do you have to urinate (pass water) more than six (6) times a day? Yes No
    - Are you thirsty much of the time? Yes No
    - Does your mouth frequently become dry? Yes No
16. Any Infectious Aerosol-Transmitted Disease or illness? (Circle if applicable)

Any flu other than seasonal flu	Diphtheria	TB (Tuberculosis)	Scarlet Fever	Pneumonia
Pertussis (whooping cough)	Parvovirus	Monkeypox	Shingles	Measles
Pharyngitis (sore throat)	Meningitis	SARS	Chickenpox	COVID-19
Epstein -Bar Virus (Mono)	Mumps	Small Pox	Strep	

17. Do you drink alcoholic beverages frequently? Yes No
18. Do you smoke or chew tobacco? Yes No
19. Have you ever taken Fen-Phen? Yes No
20. Disabilities (mental or physical)? Yes No
    Please be kind enough to explain so that we may assist with accommodations:
21. FOR WOMEN:
    a. Are you taking birth control pills? Yes No
    b. Are you possibly pregnant? If yes, week #_____

7. ACKNOWLEDGEMENT

I understand that any information I have provided, including but not limited to my personal information, my medical and dental history, is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my personal information, medical status or dental insurance.

_____

Patient Signature, or Parent/Legal Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

_____ _____

Doctor Signature Date

Medical History/Update/Doctor Comments:

_____

_____

_____

_____

Date: _____ Initials_____ Date: _____ Initials_____ Date: _____ Initials_____

Date: _____ Initials_____ Date: _____ Initials_____ Date: _____ Initials_____