RIVER VISTA DENTISTRY
GENERAL | FAMILY | COSMETIC

Dr. J. Randall Marshall • 4715 Dixie River Road, Suite A • Charlotte, NC 28273
980-224-7192 • www.RiverVistaDentistry.com

WELCOME

The benefits of a healthy, happy smile are immeasurable! Our main goal is to help you achieve and maintain your maximum oral health and a smile you are proud to show off. Please fill out this form as completely as possible. We want to make sure that we are well informed about your medical history, current medications, and any other factor that might affect your dental health and treatment. The better we communicate, the better able we are to take great care of you.

ABOUT YOU

Today's Date:_____ How did you hear about us?_____

Name (First, Middle, Last):_____

I prefer to be addressed as:_____ Circle One: Male Female

Birthdate:_____ Age:____ SS#:_____

Address:_____

City:_____ State:_____ Zip:_____

Email Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Employer:_____ Occupation:_____

Employer's Address:_____

City:_____ State:_____ Zip:_____

Circle One: Single Married Widowed Divorced Separated Partnered

Spouse's Name:_____

Spouse's Birthdate:_____ SS#:_____

Spouse's Employer:_____ Occupation:_____

When and where are the best times to reach you?_____

Other Family Members Seen by Us:_____

EMERGENCY CONTACT (Specify someone who does not live in your household)

Name:_____ Relationship:_____

Phone:_____

DENTAL HISTORY

Why have you come to our office today?_____

Previous Dentist:_____

What was done?_____

DENTAL INSURANCE

Person Responsible for Account (If other than yourself):_____

Do you have dental insurance coverage? **Yes** **No**

Dental Insurance Co. Name:_____

Dental Insurance Co. Address:_____

City:_____ State:_____ Zip:_____

Dental Insurance Co. Phone:_____

Group # (Plan, Local, or Policy#):_____

Insured's Name:_____ Relationship:_____

Insured's Birthdate:_____ SS#:_____

Insured's Home Phone:_____ Alt. Phone:_____

Insured's Employer:_____ Occupation:_____

ACKNOWLEDGEMENTS & SIGNATURES

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Signature:_____

Date:_____

I understand that I will be required to pay my estimated portion of Dr. Marshall's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature:_____

Date:_____

Are you in pain? **Yes** **No** If yes, for how long?_____

Phone:_____ Last Visit Date:_____

Date of Last Cleaning:_____ Date of Last Dental X-rays:_____

Have you ever been told that you require antibiotics before dental treatment? **Yes** **No**

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No Do you ever experience pain in your jaw joint (TMJ/TMD)? **Yes** **No**

How would you classify your current dental health? **Excellent** **Good** **Fair** **Poor** **Very Poor**

On a scale of 1-10, how would you rate your smile (10 being the best)? **1 2 3 4 5 6 7 8 9 10**

Would you like whiter teeth? **Yes** **No** Would you like fresher breath? **Yes** **No** What else about your smile would you like to change?_____

Do you feel anxiety about dental treatment? **Yes** **No** On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? **1 2 3 4 5 6 7 8 9 10**

On average, how many times a day do you brush?____ How many times a week do you floss?____ What type of bristles does your toothbrush have? **Soft** **Medium** **Hard**

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MEDICAL HISTORY

Patient Name _____ Birth Date _____

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, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Women: Are you Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

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

If yes, please explain: _____

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 Problem ☐ 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

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 _____

Date _____

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AUTHORIZATION AND RELEASE

Thank you for choosing River Vista Dentistry for your dental care. We hope to work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has inherent risks. These are seldom great enough to offset the benefits of treatment, but they should be considered when making treatment decisions. Benefits of dental treatment include: relief of pain, the ability to chew properly and enjoy eating, and the confidence and social interaction that a pleasing smile can bring. Common risks associated with virtually any dental procedure include:

- **Allergic reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
- **Long-term numbness (parasthesia).** Local anesthesia, or its administration, while almost always adequate to permit comfortable care, can result in temporary, or in rare instances, permanent numbness.
- **Muscle or joint tenderness:** Holding one's mouth open for prolonged periods of time, such as during dental treatment, can result in muscle or jaw joint tenderness. In a predisposed patient, it can precipitate a TMJ disorder.
- **Sensitivity in teeth or gums, infection, or bleeding.**
- **Swallowing or inhaling small objects.**

We follow procedural guidelines that most often lead to clinical success, but as in any other pursuit in health care, not everything always turns out the way it is planned. We will do our best to ensure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you for yourself and for your dependent(s).

My signature below indicates that I have read and understand the general risks associated with dental treatment.

_____ _____

Signature of patient or parent/guardian, if minor **Date**

AUTHORIZATION & RELEASE & PAYMENT OPTIONS

- **I authorize Dr. Marshall and River Vista Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such dental care to the third party payors and/or other health practitioners.**
- **I authorize and request my insurance company to pay directly to Dr. Marshall and River Vista Dentistry insurance benefits otherwise payable to me.**
- **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).**

PAYMENT OPTIONS

For your convenience, we offer the following methods of payments. Please check the option you prefer:

Cash _____ Personal Check _____ Visa _____ Master Card _____ CareCredit _____ I wish to discuss the financial policies _____

_____ _____

Signature of patient or parent/guardian, if minor **Date**

CONSENT TO RELEASE / REQUEST DENTAL RECORDS (if applicable)

I, _____ (patient name), do hereby consent and authorize _____ (doctor's name) to disclose to River Vista Dentistry information in my dental record, including current and previous dental records for other practitioners, hospitals, and/or clinics which are part of my record.

Patient Name: _____ Patient Date of Birth: _____

Reason for Transfer: _____

Authorization: I certify that this request has been made voluntarily and the information given above is accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Please send the following records to: **River Vista Dentistry • 4715 Dixie River Road, Suite A • Charlotte, NC 28273 • 980-224-7192 • www.RiverVistaDentistry.com**

- Radiographs
- Periodontal Charting
- Progress Notes

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act or 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

- Obtain payment from third-party payors.

- Conduct normal healthcare operations such as quality assessments and physicians certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosers of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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MEDICAL HISTORY

Primary Physician's Name: _____

Address: _____

Phone Number: _____

When was the last time you have seen your Medical Doctor? _____

Please list all medications currently taken: _____

_____

_____

_____

_____

_____

What is your chief dental concern? _____

_____

_____

_____

APPOINTMENT NO SHOW POLICY

A no show fee of 50 dollars will be charged for appointments cancelled without 48 hours notice.