Welcome to our practice!

RIVERBEND

FAMILY DENTISTRY L.L.C.

Kyle Battles, DDS

Please take a few minutes to answer the following questions so we can better assist you with your needs.

PATIENT INFORMATION

Date _____ Soc. Sec. # _____ Birthdate _____

Name _____ Home Phone _____
Last Name First Name Middle Initial

Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email _____

Sex: ❑ M ❑ F ❑ Minor ❑ Single ❑ Married ❑ Partner ❑ Divorced ❑ Widowed ❑ Separated

Employer _____ Bus. Phone _____

Business Address _____ Occupation _____

Who Should We Thank for Referring You? _____

In Case of Emergency Please Contact _____ Phone _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Responsible Party Employed By _____ Bus. Phone _____

Business Address _____ Occupation _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

SECONDARY DENTAL INSURANCE

Insured Name _____
Last Name First Name Middle Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Insured Employed By _____ Bus. Phone _____

Insurance Company _____

Insurance Company Address _____

Subscriber I.D.# _____ Group # _____

Please Complete Reverse Side

DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please Check All That Apply:

Bas Breath ..... ❑
Bleeding Gums ..... ❑
Blisters on Lips/Mouth ❑
Finger Nail Biting ..... ❑
Grinding Teeth ..... ❑
Lip or Cheek Biting ..... ❑
Loose Teeth or Broken Fillings ... ❑
Orthodontic Treatment ..... ❑
Pain Around Ear ..... ❑
Periodontal Treatment ..... ❑
Sensitivity to Cold ..... ❑
Sensitivity to Heat ..... ❑
Sensitivity to Sweets ..... ❑
Sensitivity When Biting ..... ❑
Frequent Headaches ..... ❑
Jaw, Head & Neck Injuries ..... ❑
Jaw Difficulty: Clicking and/or Pain ❑
Tooth Pain ..... ❑

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment	❑	❑
2. Have you ever had any serious illness or operations?	❑	❑
3. Are you currently taking any medications?	❑	❑
If so, please describe _____		
4. Do you smoke?	❑	❑
5. Do you use alcohol, cocaine or other drugs?	❑	❑
6. Do you wear contact lenses?	❑	❑

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. Novocaine)	❑	❑
Penicillin or other Antibiotics.	❑	❑
Sulfa Drugs	❑	❑
Barbiturates (Sleeping Pills)	❑	❑
Sedatives	❑	❑
Latex	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other	❑	❑

8. (Women only) Are You:

	Yes	No
Pregnant?	❑	❑
Nursing?	❑	❑
Taking Birth Control	❑	❑

PLEASE CHECK ALL THAT APPLY

AIDS ..... ❑
Anemia ..... ❑
Arthritis/Rheumatism ..... ❑
Artificial Heart Valves ..... ❑
Artificial Joints ..... ❑
Asthma ..... ❑
Back Problems ..... ❑
Bleeding Abdominally, with Extractions or Surgery ..... ❑
Blood Disease ..... ❑
Cancer ..... ❑
Chemical Dependency ..... ❑
Chemotherapy ..... ❑
Chronic Fatigue Syndrome ..... ❑
Circulatory Problems ..... ❑
Congenital Heart Lesions ..... ❑
Cortisone Treatments ..... ❑
Cough - persistent or bloody ..... ❑
Diabetes ..... ❑
Emphysema ..... ❑
Epilepsy ..... ❑
Fainting or Dizziness ..... ❑
Glaucoma ..... ❑
Headaches ..... ❑
Heart Murmer ..... ❑
Heart Problems ..... ❑
Hepatitis - Type ____ ..... ❑
Herpes ..... ❑
High Blood Pressure ..... ❑
HIV Positive ..... ❑
Jaundice ..... ❑
Jaw Pain ..... ❑
Latex Sensitivity ..... ❑
Kidney Disease ..... ❑
Liver Disease ..... ❑
Low Blood Pressure ..... ❑
Mitral Valve Prolapse ..... ❑
Nervous Problems ..... ❑
Pacemaker ..... ❑
Psychiatric Care ..... ❑
Radiation Treatment ..... ❑
Respiratory Disease ..... ❑
Rheumatic Fever ..... ❑
Scarlet Fever ..... ❑
Shortness of Breath ..... ❑
Sinus Trouble ..... ❑
Skin Rash ..... ❑
Stroke ..... ❑
Swelling Feet/Ankles ..... ❑
Swollen Neck Glands ..... ❑
Thyroid Problems ..... ❑
Tonsillitis ..... ❑
Tuberculosis ..... ❑
Tumor or Growth on Head/Neck. ❑
Ulcer ..... ❑
Venereal Disease ..... ❑

Signature of Responsible Party _____ Date _____