Welcome

Date:_____

PATIENT INFORMATION:

Name:_____

SS#_____ Date of birth:_____

Address:_____

City:_____ Zip:_____

Email address:_____

Phone Number:_____ Is this a cell phone or a landline (circle)

INSURANCE INFORMATION:

If an insurance card is available to be copied, this section not necessary

Policy holder name (if different than you):_____

Date of birth:_____ SS#_____

Relationship to patient:_____

Employer:_____

Name of Insurance Company:_____

ID#_____ Group#_____

HOW DID YOU HEAR ABOUT US?

_____

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Have you ever taken Fen-Phen/Redux?	☐	☐
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	☐	☐
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
7. Do you use tobacco?	☐	☐
8. Do you use controlled substances?	☐	☐

9. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other _____	☐	☐

	Yes	No
10. Are you wearing contact lenses?	☐	☐
11. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐
12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
13. Women Only:		
Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and 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 can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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 dependents.

X _____

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____

Signature _____ Date _____

Dr. Rick Rivardo
General Office Consent and Policy Disclosures

Welcome and thank you for choosing Dr. Rick Rivardo and staff to give you the highest quality and dental care available today! It is our goal to make you as comfortable and relaxed as you can be during your treatment with us. We are committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health.

Privacy Policy/Consent for Use and Disclosure of Personal Health Information:

This serves as authorization for us to use and disclose your protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities. We maintain the highest privacy standards to ensure your health information is protected. EVERY patient is provided a detailed copy, upon request. BEFORE signing, please read the Notice of Privacy Polices (that is displayed in the waiting room) to gain a clear understanding of how we may use and disclose your PHI.

I am acknowledging that I have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operation, treatment and payment activities Initial_____

Financial Policy:

Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs. Our office wants all our patients to be able to comfortably afford dental care. We offer the following payment options so our patients can have the opportunity to decide which best suits your needs:

****Cash, check or credit card**: Visa, Master Card, American Express, and Discover; Returned checks will be assessed a $50 fee to cover bank charges.
****ONLY** cash or credit card will be accepted on the first visit
****Outstanding Financing** – We use Care Credit healthcare credit company to make dental services more affordable (subject to credit approval), information given upon request; you may apply direct from our website *rivardosmiles.com*
****Rivardo Membership Plan**: We offer our own in-house discount plan to help make our patients' needs more affordable. This plan works well for patients without insurance or insurance that does not cover major work. More information is available upon request or on our website *rivardosmiles.com*
****Divorce and Responsible Party/Personal Injury Claims**: Patient is responsible for their own payments of treatment; custodial parent is responsible for minor's treatment

Revised December 2022

Assignment of Benefits Agreement:

As a courtesy to you, we will process your dental insurance claims. Payments will be sent directly to our office by "Assignment of Benefits Agreement". Most dental insurance plans do not cover 100% of your treatment cost; you will be asked for your deductibles, copayments, and out-of-pocket expenses to be **paid in full on day services are rendered**. If a statement is sent to you after treatment has been completed, it must be paid within 14 days of receiving your statement. We will estimate as closely as possible to your coverage but make no guarantees of any estimated coverage. Your insurance policy is an agreement between you and your insurance company. **The ultimate responsibility for ALL charges lies with you as well as knowing what your policy covers, coverage effective dates, deductibles and yearly maximums**. Late fees (per statement) will be applied to your account if out-of-pocket expenses are over 21 days late. Should collection proceedings be taken (after 45 days late), you will be charged the agency fees in addition to the original fees.

Initial_____

Cancellation/No-show Policy:

We recognize the importance of every patient's time and ask that you be prompt so that we may serve our scheduled patients as well as serve same day emergency patients as timely as possible. If you are unable to keep a scheduled appointment, a 24 hour notice is REQUIRED. A fee of $40 for hygiene appointment and a $60 for doctor appointment PER HOUR will be placed on your account if "no-show" or your appointment is not cancelled with the required notice. This fee must be paid prior to rescheduling your appointment.
"No Showing" or cancelling the same day of your second appointment will be an automatic dismissal from the practice

Initial_____

Patient (or parent/guardian) signature:_____

Print patient name:_____

Date:_____

Welcome to our dental family!!