Welcome to River City Dental

We are glad you have chosen us to care for you and your mouth. Patient satisfaction is our # 1 goal. Please let us know if you have any comments or suggestions, we are always looking for ways to improve our service to you.
How did you hear about us? _____

Patient Information

Last Name _____ First Name _____ MI ____
Prefers to be called _____ Date of Birth _____ Gender M F
Street Address _____ Apt. _____
City, State, Zip _____ SS # _____
Home Phone _____ Work Phone _____Cell Phone _____
Email Address _____ Preferred method of confirmation _____
Employer Name/Address _____ Occupation _____
Please list other family members treated at this practice _____
Emergency Contact Name _____ Phone _____

Dental History

What is the reason for your visit today? _____
Do you have any dental problems that you are aware of? Y N If yes, please describe _____
_____
Date of last dental visit _____ Last dental cleaning _____ Radiographs _____
Are your teeth very sensitive? Y N Do you catch food between your teeth? Y N
Do you have any pain in your jaw? Y N Do you grind your teeth? Y N
Do you feel nervous about having dental treatment? Y N If yes, what is your biggest concern?
_____
Is there anything you would like to change about your smile? _____
Is there anything else about having dental treatment you would like us to know? Y N
If yes, please describe _____

Person Responsible for this Account

Relationship to Patient: Self Spouse Parent/Guardian (If self, Please skip to Insurance section)
Last Name _____ First Name _____ MI ____
Gender M F Date of Birth _____ Does this person and patient reside in the same household? Y N
Street Address (if different) _____ Apt. _____
City, State, Zip _____ SS # _____
Home Phone _____ Work Phone _____Cell Phone _____
Employer Name/Address _____ Occupation _____

Insurance Section

Is Patient covered by Dental Insurance? Y N Name of Carrier(s) _____
Subscriber's Name _____Subscriber Number _____
Employer's Name and Address _____
Relationship to Patient: Self Spouse Parent/Guardian Date of Birth _____ Gender M F

All accounts that are 45 days or older will be charged a $50.00 late fee. Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment, and all applicable court costs. *I understand that I am financially responsible for all charges incurred, including those outstanding with the insurance company.*

Signature_____ Date _____