Welcome to River City Dental

We are glad you have chosen us to care for you and your mouth. Patient satisfaction is our number one 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 to be confirmed by_____
Employer Name/Address _____ Occupation _____
Please list other family members treated at this practice _____
Emergency Contact Name _____ Phone _____

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

I understand that I am financially responsible for all charges incurred, including those outstanding with the insurance company (if not paid in a timely manner). _____
Signature/Date

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 _____
How often do you have dental examinations? _____ Cleanings? _____
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 _____