river valley
SMILE CENTER

8309 Phoenix Ave.
Fort Smith AR 72903
479-646-0706

Patient Information Form

Thank you for selecting our office!!

Our greatest concern is your complete oral health. It is our philosophy to be a practice built on preventative dentistry rather than emergency dentistry. It is suggested that most patients are seen on a regular 4-6 month basis to consistently maintain optimum dental health.

*** Please provide Insurance Card and Photo ID for identity verification.**

Patient Name _____ SSN _____ DOB _____

___Single ___ Married ___ Widowed ___ Partnered ___ Other

___Male ___ Female

Referred By _____ Email address _____

Home Address _____ City _____ State _____ ZIP _____

Home Phone # _____ Cell Phone # _____ WK# _____

Employer _____ Address _____

Who is responsible for this account? _____ Phone # _____

Emergency Contact Person _____ Phone # _____

Dental Insurance _____ ID# _____ Group # _____

Policy Holder _____ Employer _____

Policy Holder SSN _____ DOB _____ Phone # _____

General Office Policy

1. **Payments and Co-pays are due on the day of service.**
2. Insurance: We will file your insurance claim for you as a courtesy. With the information you provide to us, we will do our best to help you determine your dental benefits. **The estimated co-pays we give you are "estimates", not a guarantee.** If your insurance does not pay, you will be responsible for the dental services you received.
3. Delinquent Accounts: In the event your account becomes delinquent as a result of non-payment of 90 days or more, it will be referred to an outside agency for collection. You will be responsible for the full account balance plus any and all fees and expenses incurred by River Valley Smile Center as a result of non-payment.
4. We would appreciate at least 24 hour notice if you cannot attend your reserved time. This will allow us time to contact other patients who are waiting for an appointment to become available. Patient's who repeatedly break scheduled appointments, are consistently late, or do not show up with no notice, may be put on a short call only status.
5. I give my permission to RVSC to store the confidential patient information I have provided, including account information, insurance information, appointment information, and clinical information, to the RVSC secure data programs. I understand that for security purposes, RVSC makes every effort to keep electronic information secure, and the RVSC program can only be accessed by internal passwords and requires a protected user ID. I understand that the dental practice is not to be held liable for any harm related to the theft of this information. I also understand that RVSC will represent all State and Federal privacy laws, as well as ethical and licensure requirements.
   * *For a more detailed description of the State and Federal privacy laws, a copy may be obtained on hhs.gov.*

I have read and understand all of the above policies.

(Name) (Date)

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing?	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS		
33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)?	☐	☐
34. Have you ever whitened (bleached) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ chlorhexidine (CHX)		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ nuts _____		
☐ fruit _____		
☐ other _____		
3. heart problems, or cardiac stent within the last six months ___	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic implant (joint replacement) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox ___	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c=_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___	☐	☐
27. arthritis _____	☐	☐
28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ___) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment _____	☐	☐
45. antidepressant medication _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches _____	☐	☐
53. a smoker, smoked previously or use smokeless tobacco ___	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)