



Steven C. Ferber, DDS

Michael D. Spencer, DDS

Andrew Maples, DMD

Today's Date ___/___/___

Email Address: _____

Patient Name: _____

Referred By: _____

Preferred Name: _____

DOB: ___/___/___ Male/Female

SS# _____ Age: ___

Address: _____

City: _____ State: _____

Employer: _____

Zip: _____

Employer's Address: _____

Home Phone: _____

Employer's Phone: _____

Cell Phone: _____

Occupation: _____

Person Ultimately Responsible for Account

Emergency Contact

Name: _____

Name: _____

Billing Address: _____

Relation: _____

Phone: _____

SS #: _____ Phone: _____

Physician Name/ #: _____

INSURANCE INFORMATION

Primary

Secondary

Company Name: _____

Company Name: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Insured SS #: _____

Insured SS #: _____

Group #: _____

Group #: _____

DOB: ___/___/___ Relation: _____

DOB: ___/___/___ Relation: _____

Insured's Name: _____

Insured's Name: _____

Insured's Employer: _____

Insured's Employer: _____

Are you generally in good health? Y / N

Are you currently under the care of a physician? Y / N

Have you had trouble with bleeding after surgery? Y / N

Do you ever have cold sores or fever blisters? Y / N

Are your teeth sensitive to hot or cold? Y / N

Have you ever had gum surgery or treatments? Y / N

Do you clench or grind your teeth? Y / N

Do you have pain in or around your ears? Y / N

Do you have an unpleasant taste in your mouth? Y / N

Do you have unexplained headaches? Y / N

Do you have clicking/ popping in your jaw or difficulty opening wide? Y / N

Have you had any reaction to a drug or anesthetic? Y / N

Please describe: _____

Please list all current medications:

Do you currently or have you ever smoked: _____ How much? _____

How often do you brush? _____ How often do you floss? _____

What would you like to improve about your teeth? _____

AIDS/HIV	Y / N	High Blood Pressure	Y / N	Asthma	Y / N
Joint Replacement	Y / N	Arthritis	Y / N	Kidney Disease	Y / N
Cancer	Y / N	Liver Disease	Y / N	Diabetic	Y / N
Lung Disease	Y / N	Epilepsy/Seizures	Y / N	Mitral Valve Prolapse	Y / N
Fainting/Dizziness	Y / N	Radiation Therapy	Y / N	Glaucoma	Y / N
Rheumatic Fever	Y / N	Hepatitis	Y / N	Stomach Ulcers	Y / N
Heart Disease	Y / N	Stroke	Y / N	Heart Murmur	Y / N
Thyroid Disease	Y / N	Heart Pacemaker	Y / N	Tuberculosis	Y / N
Heart Valve Surgery	Y / N	Pregnant now?	Y / N		

I authorize release of medical or other necessary information to process insurance claims. I authorize payment of medical and/or dental benefits to Riverside Dental.

Signed: _____ Date: _____

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I understand I am responsible for any balance not paid by my insurance company and any balance through self-pay.

Signed: _____ Date: _____

I acknowledge I have read and/or received a copy of this office's Notice of Privacy Policy Practice.

Signed: _____ Date: _____



FINANCIAL POLICY

Our office policy is payment is due at the time services are rendered.

As a courtesy, we will verify your dental benefits and file your claim at the time of treatment (PPO plans only). Your insurance policy is an agreement between you and your insurance company; we are not a party to that agreement. You will be required to pay your deductible and co-pay when services are rendered. Once we receive your insurance payment we will reconcile your account and either mail an invoice to you DUE UPON RECEIPT, or mail you a refund check. Ultimately, you are responsible for the entire balance for all treatment provided.

Our treatment recommendations are based on your needs and preventive measures to help you keep your teeth for your lifetime. Dental insurance is simply a payment method.

Full payment is due at time of service with cash, credit card or check. All returned checks will be subject to a \$35 fee.

Accounts with an outstanding balance more than 90 days from the statement date will be reported to our collection agency.

APPOINTMENT POLICY

Unless cancelled at least two business days in advance, a \$50 fee will be applied to your account. This fee may be waived with the completion of a follow up appointment within a two week period.

Appointment times are extremely important, especially to those patients in need of treatment.

In addition, if you are more than 15 minutes late, we may ask you to reschedule your appointment.

I have read and agree to the Financial and Appointment Policy. I authorize the release of any information relating to medical or dental claims and benefits payable to Riverside Dental.

Signature of Patient / Responsible Party

Date



Authorization For and Release of Dental Photographs and/or Digital Images

This is a consent document that has been prepared to help inform you concerning permission to create permanent images via film and/or digital imaging. For the intent and purpose defined within this consent document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by Riverside Dental.

Introduction

Dental images may be taken before, during and/or after treatment, surgical procedures or consultations. Consent is required to take such images.

Consent to Take Photographs and Digital Images

I hereby authorize Riverside Dental and Associates to take pre-operative, intra operative, and post-operative images, I additionally consent to images of pre and post treatment photographs.

Patient Name: _____

Patient Signature _____

Witness Signature _____

Date _____