

# R+R Dental

COSMETIC + FAMILY DENTISTRY



Nadia M. Rivera, DMD  
Michael C. Richer, DDS

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
Would you like to receive notifications through text and/or e-mail?  
\_\_\_ Yes, I would like to receive text notifications \_\_\_ Yes, I would like to receive e-mail notifications  
Subscriber Employer: \_\_\_\_\_ Dental Insurance Carrier: \_\_\_\_\_  
Insurance ID: \_\_\_\_\_ Subscriber SSN: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

**Please check Y=Yes or N=No if you have any of the following conditions:**

Do your gums bleed when you brush? \_\_\_\_\_ Y \_\_\_ N  
Have you ever had orthodontic (braces) treatment? \_\_\_\_\_ Y \_\_\_ N  
Are your teeth sensitive to cold, hot, sweets, or pressure? \_\_\_\_\_ Y \_\_\_ N  
Do you have earaches/neck pains? \_\_\_\_\_ Y \_\_\_ N  
Have you had any periodontal (gum) treatments? \_\_\_\_\_ Y \_\_\_ N  
Do you wear removable dental appliances? \_\_\_\_\_ Y \_\_\_ N  
How would you describe your current dental problem? \_\_\_\_\_  
Date of your last dental exam? \_\_\_\_\_  
Date of last dental x-rays? \_\_\_\_\_  
How do you feel about the appearance of your teeth? \_\_\_\_\_

**If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.**

Have you had any of the following diseases or problems?  
Active Tuberculosis \_\_\_\_\_ Y \_\_\_ N  
Persistent cough greater than a 3 week duration \_\_\_\_\_ Y \_\_\_ N  
Cough that produces blood \_\_\_\_\_ Y \_\_\_ N

Do you have, or have you had clicking, popping or pain in your tempromandibular joints (TMJ)? \_\_\_\_\_

Have you been hospitalized in the past five years? If yes, please explain:  
\_\_\_\_\_

Are you under a physician's care presently? If yes, please explain:  
\_\_\_\_\_

Are you currently taking any medications? If yes, please list:  
\_\_\_\_\_

Have you ever been a drug or substance abuser? \_\_\_\_\_ Y \_\_\_ N  
Do you use tobacco products? \_\_\_\_\_ Y \_\_\_ N  
Are you happy with your smile? \_\_\_\_\_ Y \_\_\_ N  
Would you like to have whiter teeth? \_\_\_\_\_ Y \_\_\_ N

Please check Y=Yes or N=No

Are you allergic to any of the following?:

Local anesthetics	__Y__N	Latex	__Y__N
Aspirin	__Y__N	Iodine	__Y__N
Penicillin	__Y__N	Hay fever/seasonal	__Y__N
Sulfa Drugs	__Y__N	Animals	__Y__N

Other \_\_\_\_\_  
To yes responses, specify type of reaction. \_\_\_\_\_

Do you have a cardiovascular disease? If yes, specify below:

__Angina	__Heart Murmur
__Arteriosclerosis	__High blood pressure
__Artificial heart valves	__Low blood pressure
__Congenital heart defects	__Mitral valve prolapse
__Congestive heart failure	__Pacemaker
__Coronary artery disease	__Rheumatic heart disease
__Damaged heart valves	__Rheumatic fever
__Heart attack	

Do you have any of the following conditions?

Chest pain upon exertion	__Y__N
Chronic pain	__Y__N
Disease, drug, or radiation-induced immunosuppression	__Y__N
Diabetes? If yes, specify below.	__Y__N
__Type 1 (insulin dependent) __Type 2	

Dry Mouth	__Y__N	Kidney Problems	__Y__N
Eating Disorder	__Y__N	Mental Health Disorder	__Y__N
If yes, specify _____			
Epilepsy	__Y__N	Malnutrition	__Y__N
Fainting spells/seizures	__Y__N	Night Sweats	__Y__N
Gastrointestinal disease	__Y__N	Neurological disorders	__Y__N
G.E. Reflux/persistent heartburn	__Y__N	Osteoporosis	__Y__N
Glaucoma	__Y__N	Persistent swollen glands	__Y__N
Hemophilia	__Y__N	Respiratory problems	__Y__N
Hepatitis __A__B__C	__Y__N	Sinus trouble	__Y__N
Severe headaches/migraines	__Y__N	Sleep Disorder	__Y__N
Severe/Rapid weight loss	__Y__N	Sores/Ulcers in mouth	__Y__N
Sexually transmitted disease	__Y__N	Stroke	__Y__N
Systemic lupus erythematosus	__Y__N	Ulcers	__Y__N
Tuberculosis	__Y__N	Excessive Urination	__Y__N
Thyroid problems	__Y__N		

If yes to any of the following above, please explain: \_\_\_\_\_

Do you have any disease, condition, or problem not listed above that you think I should know about? \_\_\_\_\_

Please add anything you feel is important for the doctor to know: \_\_\_\_\_

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?  Y  N

If yes, when and what was done during this operation? \_\_\_\_\_

**WOMEN ONLY**

Are you or could you be pregnant?  Y  N

Are you nursing?  Y  N

Taking birth control pills or hormonal replacement?  Y  N

**HOW DID YOU HEAR ABOUT US?**

Clipper magazine  Insurance website

Pennysaver  Friend/Family  
If yes, who? \_\_\_\_\_

Sign/Walk in

Other

Internet

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Full name: \_\_\_\_\_ Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address above. Please understand that revocation of this Consent will not affect any action we took before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Signature**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_