Clarksville Smiles
Richard C. Ribeiro, DDS
Family • Cosmetic • Implant Dentistry

Richard C. Ribeiro, D.D.S.
2305 Rudolphtown Blvd.

Today's Date _____

Mr.
Mrs.
Ms._____ Birthdate _____Age _____ Soc. Sec. No. _____
Patient's Last Name First Name Initial

Home Address _____ City _____ Zip _____ Phone No. _____

Driver's License No. _____ E-mail Address _____ Cell Phone_____

Occupation _____ Employer _____ City _____

Person Responsible _____ Relationship To You _____ Soc. Sec. No. _____

Billing Address _____ City _____ Zip _____ Business Phone _____

Spouse Name _____ DOB _____ Employer _____ Soc. Sec. No. _____

How did you hear about our office? ❑ Phone Book ❑ Advertisement ❑ Relative/Friend _____

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation _____

Insured's Birthday _____/_____/_____

Insured's SS#/ID # _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____ Relation _____

Insured's Birthday _____/_____/_____

Insured's SS#/ID # _____

Insured's Employer: _____

Office Policy

Please notify the office staff, prior to seeing the dentist or hygienist of any changes in address, phone numbers, and changes in medical history or insurance coverage.

As we reserve time with the dentist for your appointments, it is very important that we receive notice of a change in plans at least 24 hours in advance. Clarksville Smiles reserves the right to charge a $35 fee for missed appointments. If appointments are missed or cancelled, we reserve the right to no longer pre-schedule any further appointments.

A parent or legal guardian must sign for and be present for the entirety of the scheduled appointment for any children under the age of 18 years old.

Due to the quiet, calm environment of Clarksville Smiles, please limit cell phone usage to emergency situations.

Please See Reverse Side

Clarksville Smiles

MEDICAL HISTORY

PATIENT NAME _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If yes _____

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If yes _____

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If yes _____

Are you taking any medications, pills or drugs? ❍ Yes ❍ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No

Do you use tobacco? ❍ Yes ❍ No

Are you on a special diet? ❍ Yes ❍ No

Do you use controlled substances? ❍ Yes ❍ No

Women: Are you ❑ Pregnant ❑ Trying to get pregnant? ❑ Nursing? ❑ Taking oral contraceptives?

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Other

Do you have, or have you had any of the following?

❑ AIDS/HIV Positive	❑ Chest Pains	❑ Frequent Headaches	❑ Irregular Heartbeat	❑ Scarlet Fever
❑ Alzheimer's Disease	❑ Cold Sores/Fever Blisters	❑ Genital Herpes	❑ Kidney Problems	❑ Shingles
❑ Anaphylaxis	❑ Congenital Heart Disorder	❑ Glaucoma	❑ Leukemia	❑ Sickle Cell Disease
❑ Anemia	❑ Convulsions	❑ Hay Fever	❑ Liver Disease	❑ Sinus Trouble
❑ Angina	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Low Blood Pressure	❑ Spina Bifida
❑ Arthritis/Gout	❑ Diabetes	❑ Heart Murmur*	❑ Lung Disease	❑ Stomach/Intestinal Disease
❑ Artificial Heart Valve*	❑ Drug Addiction	❑ Heart Pace Maker*	❑ Mitral Valve Prolapse*	❑ Stroke
❑ Artificial Joint*	❑ Easily Winded	❑ Heart Trouble/Disease	❑ Pain in Jaw Joints	❑ Swelling of Limbs
❑ Asthma	❑ Emphysema	❑ Hemophilia	❑ Parathyroid Disease	❑ Thyroid Disease
❑ Blood Disease	❑ Epilepsy or Seizures	❑ Hepatitis A	❑ Psychiatric Care	❑ Tonsillitis
❑ Blood Transfusion	❑ Excessive Bleeding	❑ Hepatitis B or C	❑ Radiation Treatments	❑ Tuberculosis
❑ Breathing Problem	❑ Excessive Thirst	❑ Herpes	❑ Recent Weight Loss	❑ Tumors or Growths
❑ Bruise Easily	❑ Fainting Spells/Dizziness	❑ High Blood Pressure	❑ Renal Dialysis	❑ Ulcers
❑ Cancer	❑ Frequent Cough	❑ Hives or Rash	❑ Rheumatic Fever*	❑ Venereal Disease
❑ Chemotherapy	❑ Frequent Diarrhea	❑ Hypoglycemia	❑ Rheumatism	❑ Yellow Jaundice

Have you ever had any serious illness not listed above? ❍ Yes ❍ No ❍ N/A _____

Comments: _____

_____

_____

*Condition may require medication N/A - Not answered by patient

Upon explanation and agreement of the dental procedure(s), I consent to the necessary treatment of the above named patient. I also agree to assume full financial responsibility for all treatment rendered, reasonable attorney fees, and collection costs.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT or GUARDIAN DATE