Jacob L. Revercomb, DDS

Revercomb DENTAL GROUP

Joseph J. Russo, DDS

Confidential Patient Information

Date:_____

Patient Name: _____ _____
Last First MI prefer to be called

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell phone:_____

Address: _____
Street Apartment #

_____
City State Zip Code

E-mail address:_____

Employer Name:_____Occupation:_____

Address:_____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Address: _____
Street City State Zip Code

IN CASE OF EMERGENCY CALL: _____

Referral Information

Whom may we thank for referring you to our practice?_____

Health Information

Date of your last physical_____Physician Name:_____

Have you been hospitalized in the past two years?_____

Have you had any of the following? Please check those that apply:

☐ AIDS
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy/Nursing**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ trouble w/ Epinephrine
☐ Codeine Allergy
☐ Penicillin Allergy

Source of water
☐ well ☐ city/public

☐ Alcohol Dependency
☐ Night Sweats
☐ Latex Allergy
☐ Blood thinners

Ever taken Phen/Phen (Redux or Pondimin)?
_____

Are you taking any bisphosphonates (meds for osteoporosis)?_____

Do you suffer with migraines?_____

Do you snore?___

- Have you ever had any complications following dental treatment? Yes_____No_____
  If yes, please explain:_____
- Are you presently taking any medications including birth control? Yes_____No_____
  If yes, please explain:_____
- Are you now under the care of a physician? Yes_____No_____
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____

- Do you have any health problems that need further clarification? Yes_____No_____
  If yes, please explain:_____
- Do you use any tobacco products? Yes_____No_____ How long?_____How much_____
- Do you experience difficulty when swallowing? Yes_____No_____

Dental History

Purpose of this dental visit_____
Date of last dental examination:_____Date of last x-rays:_____
Are you having pain or discomfort at this time? Yes_____No_____
Do you feel very nervous about having dental treatment? Yes_____No_____
Have you ever had a bad experience in a dental office ? Yes_____No_____
Are there now any growths or sores in or around your mouth? Yes_____No_____
Do you have any trouble chewing? Yes_____No_____
Does food catch between your teeth? Yes_____No_____
Do you have pain in or near your ears? Yes_____No_____
Do you habitually clench or grind your teeth during the day or night? Yes_____No_____
Have you ever been told you have gum problems? Yes_____No_____
Do you now have bleeding gums or any other gum condition? Yes_____No_____
Do you like the color of your teeth? Yes_____No_____
Would you like it, if we could, straighten your teeth without braces? Yes_____No_____
Do you have spaces you do not like? Yes_____No_____
If yes, please explain_____
Do you like the shape of your teeth? Yes_____No_____
If no, please explain_____
Are there old fillings or dental work that you don't like looking at? Yes_____No_____
If yes, explain_____
What would you like to change the most in the appearance of your teeth?_____

If you have insurance, please present a card or completed form to one of our staff at the front desk

CONSENT FOR TREATMENT AND FINANCIAL ARRANGEMENT

TO THE BEST OF MY KNOWLEDGE, ALL OF THE INFORMATION ON BOTH SIDES OF THIS FORM IS TRUE AND CORRECT. IF THERE IS ANY CHANGE IN MY HEALTH OR MY MEDICATIONS, I WILL INFORM THE DOCTOR PRIOR TO ANY TREATMENT.

I AUTHORIZE THE DOCTORS AND/OR THEIR STAFF TO TREAT THE ABOVE NAMED PATIENT. I WILL CONTACT THE DOCTOR'S OFFICE IF I HAVE ANY ADDITIONAL QUESTIONS OR THERE ARE ANY UNEXPECTED REACTIONS TO TREATMENT. I REALIZE THAT THE RESULTS OF CERTAIN PROCEDURES CANNOT BE GUARANTEED.

ALL FINANCIAL ARRANGEMENTS WILL BE MADE PRIOR TO TREATMENT. I REALIZE THAT, ULTIMATELY, I AM COMPLETELY RESPONSIBLE FOR PAYMENT OF ALL TREATMENT. THE OFFICE WILL ASSIST BY FILING ALL NECESSARY INSURANCE PAPERWORK.

I REALIZE THAT THE FEE ESTIMATE LISTED FOR DENTAL CARE IS VALID FOR ONLY SIX MONTHS.

I HAVE READ AND FULLY UNDERSTAND THE CONDITIONS OF TREATMENT AS STATED.

SIGNATURE:_____
DATE:_____

I have reviewed my medical history and the above (including any changes) is accurate:

Date/Initials: _____ **Date/Initials:** _____ **Date/Initials:** _____
Date/Initials: _____ **Date/Initials:** _____ **Date/Initials:** _____
Date/Initials: _____ **Date/Initials:** _____ **Date/Initials:** _____