Michelle Wang, DMD
1103 Rivery Blvd. Suite 140
Georgetown, TX 78628
Phone: (512) 763 - 7606

Patient Information

Welcome to Rivery Dental. Thank you for choosing our office for your dental care. Our primary goal is to help you achieve and maintain your maximum oral health with a smile you are proud to show off. Please fill out this form as completely as possible. If you have any questions or concerns, please ask us for assistance. We will be happy to help.

Your Name: _____ Name you wish to be called: _____ Date: _____

Physical Address: _____
Street Name and Number City Zip Code

Mailing Address: _____
Street Name and Number or PO Box City Zip Code

Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Circle one: Single Married Widowed Separated Divorced Sex: Male Female Age: _____ Birth date: _____

Occupation: _____ Employer: _____ Patient's Social Sec. #: _____
Employer Address and Phone #: _____
Spouse Name: _____ Spouse Birth Date: _____ Social Sec. #: _____
Spouse Occupation: _____ Spouse's Employer: _____

Who may we thank for referring you: _____ *Otherwise, how did you hear about us:* _____

IN CASE OF EMERGENCY, PLEASE CONTACT (someone NOT living with you)

Name: _____ Relationship to you: _____
Phone Numbers (Home and Cell): _____ Address: _____

*****If you gave us a copy of your insurance card, there is no need to fill this part out*****

Insurance Company: _____ Insurance Phone #: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Social Security #: _____ Policy Holder's Birth Date: _____

Is the patient covered by a secondary insurance: YES NO *If yes, continue*:
Name of Secondary Insurance: _____ Insurance Phone #: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Social Security #: _____ Policy Holder's Birth Date: _____

I understand that I will be required to pay my estimated portion of Dr. Michelle Wang's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Patient Signature: _____ Date: _____

Dental History

Patient Name: _____ *Date of Birth:* _____

Reason for today's visit: _____

Why have you come to our office today? _____ Are you in pain? YES NO If yes, for how long? _____

Previous Dentist: _____ Phone: _____ Last visit date: _____

What was done? _____ Date of last cleaning: _____ Date of last dental X-rays: _____

Have you ever been told that you require antibiotics before dental treatment? YES NO

Do you have or have you ever had any of the following conditions, ailments, or treatments? Circle "Yes" or "No"

Bad Breath	YES	NO	Food Collection Between Teeth	YES	NO	Orthodontic Treatment	YES	NO
Bleeding Gums	YES	NO	Foreign Objects in Mouth	YES	NO	Pain Around Ear	YES	NO
Blisters on Lips or in Mouth	YES	NO	Grinding Teeth	YES	NO	Pain When Brushing	YES	NO
Broken Fillings	YES	NO	Gum Swollen or Tender	YES	NO	Periodontal Treatment	YES	NO
Burning Sensation on Tongue	YES	NO	Jaw Pain	YES	NO	Sensitivity to Cold	YES	NO
Chew on Only One Side	YES	NO	Jaw Fatigue	YES	NO	Sensitivity to Heat	YES	NO
Clenching of Teeth	YES	NO	Lip or Check Biting	YES	NO	Sensitivity to Sweets	YES	NO
Clicking or Popping of Jaw	YES	NO	Loose Teeth	YES	NO	Sensitivity When Chewing	YES	NO
Dry Mouth	YES	NO	Mouth Breathing	YES	NO	Sores or Growths in Mouth	YES	NO

Have you ever had a serious/difficult problem associated with any previous dental work? YES NO

Do you ever experience pain in your jaw joint (TMJ/TMD)? YES NO

How would you classify your current dental health? Excellent Good Fair Poor Very Poor

On a scale of 1-10, how would you rate your smile (10 being the best)? _____

Would you like whiter teeth? YES NO

Would you like fresher breath? YES NO

What else about your smile would like to change? _____

Do you feel anxiety about dental treatment? YES NO

On a scale of 1-10, how would you rate your anxiety (10 being the most anxious)? _____

On average, how many times a day do you brush? _____ How many times a week do you floss? _____

What type of bristles does your toothbrush have? Soft Medium Hard

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I give my consent for Dr. Michelle Wang to do a complete and thorough examination, including any diagnostic radiographs needed. I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Patient Signature: _____ Date: _____

Medical History

Patient Name: _____ *Date of Birth:* _____

Do you have a physician? YES NO Physician's name: _____ Phone: _____
Date of last physical: _____ Current physical health: Excellent Good Fair Poor Very Poor
Are you currently under the care/supervision of a physician? YES NO Please explain: _____
Have you ever had a serious injury to the head or neck? YES NO Please explain: _____
Are you currently taking any prescription medications? YES NO Please list medication with correlating diagnosis: _____
_____
Do you or have you ever used tobacco in any form? YES NO If yes, how much? _____ For how long? _____

Allergies – check any and all of the following to which you are allergic:

☐Aspirin	☐Dental Anesthetics	☐Jewelry/Metals	☐Penicillin
☐Barbiturates/Sleeping pills	☐Erythromycin	☐Latex	☐Teracycline
☐Codeine	☐Ibuprofen/Motrin	☐Percocet	☐Vicodin

Please list any other medications and/or materials to which you think you are allergic: _____

Do you have or have you ever had any of the following conditions? Circle "Yes" or "No"

Anemia	YES	NO	Abnormal Bleeding	YES	NO	Arthritis	YES	NO
Congenital Heart Lesions	YES	NO	Blood Disease	YES	NO	Cortisone Treatments	YES	NO
Rheumatic Fever	YES	NO	HIV	YES	NO	Asthma	YES	NO
Heart Murmur	YES	NO	AIDS	YES	NO	Other Respiratory Issues	YES	NO
Heart Attack	YES	NO	Hepatitis	YES	NO	Stroke	YES	NO
If Yes, Year: _____			If Yes, Type_____			If Yes, Year: _____		
Artificial Heart Valves	YES	NO	Jaundice	YES	NO	Scarlet Fever	YES	NO
Other Heart Conditions	YES	NO	Psychiatric Care	YES	NO	Thyroid Problems	YES	NO
High Blood Pressure	YES	NO	Nervous Problems	YES	NO	Tuberculosis	YES	NO
Low Blood Pressure	YES	NO	Epilepsy	YES	NO	Kidney Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Fainting	YES	NO	Liver Disease	YES	NO
Cardiac Pacemaker	YES	NO	Vertigo	YES	NO	Special Diet	YES	NO
Angina (Chest Pains)	YES	NO	Diabetes	YES	NO	Stomach Trouble	YES	NO
Cancer	YES	NO	Glaucoma	YES	NO	Herpes	YES	NO
Chemotherapy	YES	NO	Head/Neck/Mouth Tumors	YES	NO	Artificial Joint	YES	NO
Radiation Therapy	YES	NO	Hospital Stays	YES	NO	Replacement Joints	YES	NO
			If Yes, explain: _____					

Circle medicine you have taken

-Actonel -Bisphosphonates
-Boniva -Cialis - Fosamax
-Levitra -Viagra -Revati

Recreational drugs	YES	NO
Controlled legal drugs	YES	NO

FOR WOMEN:

Are you pregnant	YES	NO
If yes, due date: _____		
Nursing?	YES	NO
Birth control pills	YES	NO

Do you have any other conditions or illnesses not listed here YES NO If yes, please list/explain: _____
_____

I give my consent for Dr. Michelle Wang to do a complete and thorough examination, including any diagnostic radiographs needed. I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

Patient Signature: _____ Date: _____

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Child Information

Your Name: _____ Name you wish to be called: _____ Date: _____

Physical Address: _____
Street Name and Number City Zip Code

Mailing Address: _____
Street Name and Number or PO Box City Zip Code

Sex: Male Female Age: _____ Birth Date: _____

Parent, Guardian, Responsible Party Info:

Name of person responsible for this account: _____ Relationship: _____

Physical Address: _____
Street Name and Number City Zip Code

Email Address: _____ Home/Cell Phone: _____

Employer: _____ Work Phone: _____

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Name: _____ Relationship to you: _____
Phone Numbers (Home and Cell): _____ Address: _____

Who may we thank for referring you: _____ *Otherwise, how did you hear about us?* _____

*****If you gave us a copy of your insurance card there is no need to fill out the Insurance portion*****

Insurance Company: _____ Insurance Phone #: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Social Security #: _____ Policy Holder's Birth Date: _____

Is the patient covered by a secondary insurance: Yes / No *If yes, continue*:
Name of Secondary Insurance: _____ Insurance Phone #: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Policy Holder's Social Security #: _____ Policy Holder's Birth Date: _____

ASSIGNMENT AND RELEASE:

I certify that my dependent has insurance coverage with the company listed above and authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Patient Name: _____

Dental History

Reason for Today's Visit: _____

Former Dentist (optional) : _____ Date of Last Dental Visit: _____

Please circle Yes or No:

- Does the child have any mouth habits? YES NO
  If yes, circle to which: Thumb sucking Nail biting Pacifier Sleeps w/ bottle Other: _____
- Any past serious problem with dental treatment? YES NO
  If yes explain:_____
- Any unhappy dental experiences YES NO
- *If yes, explain*:_____
- Is child a mouth breather? YES NO
- Has child ever had sedation dentistry? YES NO
- Does child brush teeth daily? YES NO
- Is fluoride taken in any form? YES NO
- Other dental issues not listed above YES NO
  Please explain: _____

Medical History

Primary Physician's Name: _____ Date of Last Physical: _____
Pharmacy Name: _____ Phone #: _____

Is child under the care of physician now	YES	NO
Is child receiving medications?	YES	NO
Any hospitalizations?	YES	NO
Any surgeries?	YES	NO

Current Medications (Type no if none): _____

_____

Allergies (Type no if none): _____

Has child had any history with any of the following?

AIDS/HIV	YES	NO	Anemia	YES	NO	Diabetes	YES	NO
Bladder issues	YES	NO	Cancer	YES	NO	Cerebral palsy	YES	NO
Chicken pox	YES	NO	Fainting	YES	NO	Liver disorder	YES	NO
Asthma	YES	NO	Convulsions	YES	NO	Hearing issues	YES	NO
Measles	YES	NO	Thyroid issues	YES	NO	Heart problems	YES	NO
Tuberculosis	YES	NO	Mumps	YES	NO			

*Other illnesses /conditions not listed YES NO (IF YES, EXPLAIN) _____

AUTHORIZATIONS:

I am the parent, guardian, or personal representative of _____, and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor whether or not I am present when the treatment is rendered.

Responsible Party Signature: _____ Relationship: _____ Date: _____

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FINANCIAL AND INSURANCE POLICIES

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our FINANCIAL AND INSURANCE POLICIES. If you have any questions, please do not hesitate to ask us.

1. VERIFYING INSURANCE: As a courtesy to you, we will verify your insurance for eligibility benefits prior to your new patient appointment as well as any time that you notify us of a change in your coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ultimately responsible for knowing if there are any waiting periods of work to be performed. Any amounts on your treatment plans that are not covered by your insurance are your financial responsibility.
2. PAYMENT: Payment is due at the time of service. Additionally, if you have a balance following an insurance payment from a previous visit, you will be expected to pay that amount as well.
3. INSURANCE INFORMATION: New insurances as well as changes in insurance must be provided to this office prior to an appointment. Failure to provide correct and current insurance information may result in the entire bill being your responsibility.
4. CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be kept current with our office.
5. REQUESTS FOR ADDITIONAL INFORMATION: These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being your responsibility.
6. PAYMENT PLANS: Our office offers Third Party Financing and In-House Dental Plan if needed to assist you in paying for any necessary treatment.
7. BALANCES: Our office will not carry balances longer than 90 days, regardless of pending insurance payment. A finance charge of 1.5% per month (18% per annum) will be added to your account exceeding 90 days, unless previously written financial arrangements are satisfied.
8. RETURNED CHECKS: There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash, or credit card. Once a check has been returned, this office will no longer accept your personal checks for payment.
9. CANCELLATION / FAILED APPOINTMENTS: We request 24-hours notice if you are cancelling an appointment. There will be a $25 fee for cancellations made without 24 hours notice and for failed appointments ("no shows"). The $25 will be posted to your account, and you will not be allowed to make any other appointments for yourself or your family members until it is paid in full.

Thank you for reading this information in full. Please sign below to acknowledge your understanding of the FINANCIAL AND INSURANCE POLICIES

Patient or Guardian Signature: _____ Date: _____

Patient Name (Please Print): _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(Please sign)

_____
(Date)

We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare, or with payment for your healthcare, but only if you agree that we may do so.

Please list with whom we may discuss your treatment:

_____

_____

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)