PATIENT INFORMATION Date ____ /____ /_____

Patient's Name____
Last First Middle (Preferred Name)

Address____
Street City State Zip

Birth Date____ /____ /___ Social Security#____ -____ -_____

Home Phone______________________ Spouse/Other____________________

Work Phone ______________________ E-Mail___________________________

Cell Phone _______________________ Pharmacy________________________

Employer _________________________ Occupation______________________

Preferred Hygienist____

Emergency Contact Person____
Full Name Phone Number Relationship

COLLEGE STUDENT INFORMATION Student Status: Full-time Part-time (Circle one)

College Name_____________________ City___________________ State________

NEW PATIENT INFORMATION Date of last dental visit____ /___ /______

Previous Dentist Name_______________________ Phone___________________

Recent Films Have you had films taken within the last three years? ___Yes __ No

☐ If you are planning to call your previous dentist to request your recent films please "X" the box. Films may be sent to: River Pines Dental, 925 Hwy 55 Suite #104, Hastings, MN 55033

Medications Have you ever been advised to take antibiotic medication prior to dental treatment? ___ Yes ___ No

Name of Prescribed Med.______________________ Amount Prescribed________

Please “X” the boxes that apply:
☐ I have a heart murmur or existing heart condition.
☐ I have had rheumatic fever.
☐ I had joint replacement within the last 2 years.

Physician’s Name____________________________ Phone_____________________

Pharmacy_____________________ City___________ Phone_____________________

Referrals How did you learn about our office? Friend Relative

Employee Newspaper Website Other

Who may we thank if a friend relative or employee, for this referral?_________________

RESPONSIBLE PARTY INFORMATION

Name____ Marital Status_________
Last First Middle

Address____
Street City State Zip

Relationship to Patient______________ Social Security#____ -____ -_____

Home Phone_________________________ Birth Date _____ /_____ /_____

Work Phone__________________ Ext____ E-mail_______________________

Cell Phone___________________________

PRIMARY INSURANCE INFORMATION Insured’s Birth Date ____/____ /_____

Insured Person’s Name_______________ Social Security#______ -____ -____

Employer______________________________ Insurance Company______________

Insurance Company Address____

Insurance Phone #_____________ Group #_________ ID#_____________

Relationship to Patient _____Self______Spouse_______Parent______Other

SECONDARY INSURANCE INFORMATION Insured's Birth Date__/____/_____

Insured Person's Name_____________ Social Security#_____-____ -____

Employer___________________________Insurance Company____________

Insurance Company Address____

Insurance Phone #_____________ Group #_________ ID#_____________

Relationship to Patient _____Self______Spouse_______Parent______Other

☐ I give River Pines Dental permission to call my residence even though my name may appear on the National Do Not Call Registry.

Patient/Guardian Signature:____

Updates and Initials____________ _______________ _______________

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