RG Dental Group Of Richboro
56 Newtown Richboro Rd
Richboro, PA 18954
Ph # : 215-355-6406
Fax # : 215-357-5718

RG Dental Group
of Richboro

Patient Personal Information

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				**Do you have Secondary Dental Insurance?** __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To

- ☐ Y ☐ N No Known Allergies
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates / Sleeping Pills
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Metals
- ☐ Y ☐ N No Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Prior Hepatitis
- ☐ Y ☐ N Sulfa Drugs
- ☐ Y ☐ N Other Narcotics

Check, if applicable

- ☐ Y ☐ N Anorexia
- ☐ Y ☐ N Arteriosclerosis
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma
- ☐ Y ☐ N Autoimmune Disease
- ☐ Y ☐ N Bladder Trouble
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bulimia
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Cardiovascular Disease
- ☐ Y ☐ N Chemotherapy
- ☐ Y ☐ N Chest Pain Upon Exertion
- ☐ Y ☐ N Color Blindness
- ☐ Y ☐ N Fainting Spells
- ☐ Y ☐ N Fever Blisters
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Frequently Dry Mouth / Sjogren
- ☐ Y ☐ N Gag Reflex
- ☐ Y ☐ N Gall Bladder Trouble
- ☐ Y ☐ N Hay Fever
- ☐ Y ☐ N Heart Attack
- ☐ Y ☐ N Heart Disease
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis
- ☐ Y ☐ N Herpes
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Hives
- ☐ Y ☐ N Jaundice
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Radiation Treatment
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Rheumatoid Arthritis
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Skin Rash
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss

☐ Y ☐ N No Change Since Last Recorded
☐ Y ☐ N No Known Concerns or Issues
☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N AIDS/HIV Infection
☐ Y ☐ N Alcohol/Drug Abuse
☐ Y ☐ N Angina
☐ Y ☐ N Anemia
☐ Y ☐ N Ankles Swell
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Contact Lenses
☐ Y ☐ N Congestive Heart Failure
☐ Y ☐ N Damaged Heart Valve
☐ Y ☐ N Diabetes
☐ Y ☐ N Emphysema
☐ Y ☐ N Environmental Allergies
☐ Y ☐ N Epilepsy
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Lupus
☐ Y ☐ N Mental Health Problems
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Pacemaker
☐ Y ☐ N Urinate Frequently

Other

☐ Y ☐ N See Scanned Documents: Pt Note

Dental Questionnaire

Dental Questionnaire

Name of previous Dentist _____

Phone _____

Date of your last cleaning _____

Last exam date _____

Date of your last full series x-rays _____

Date of last cavity detection (bitewing) x-rays _____

Do your gums bleed while brushing or flossing ? _____

Are your teeth sensitive to hot, cold or sweets ? _____

Do you get frequent fever blisters, mouth ulcers, or sores on your lips or in your mouth ? _____

Have you ever had burning of the tongue or cracking of the corners of your mouth ? _____

Do you chew/smoke tobacco in any form ? _____

Have you had any head, neck or jaw injuries ? _____

Do you notice popping, clicking or soreness of the jaws or points just in front of the ears ? _____

Do you clench or grind your teeth ? _____

Have you ever had orthodontic treatment ? _____

If Yes, date of placement _____

Do you wear dentures or partials ? _____

If Yes, date of placement of dentures ? _____

Are you happy with your dentures ? _____

Are you having any specific problems with your teeth, gums, or mouth at this time ? _____

Are you happy with your smile ? _____

Do you have problems with teeth/fillings breaking ? _____

Do you regularly use dental floss ? _____

Do you have, or have you ever been told, that you have Pyorrhea (Periodontal Disease) ? _____

Do you have difficulty in opening your mouth widely ? _____

Do you have an unpleasant taste or odor in your teeth/mouth ? _____

Does food catch between your teeth ?

Do you want to learn to control your dental disease and retain your teeth ?

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list

Medical Questionnaire

Emergency Contact

Emergency contact name

Emergency contact phone

Emergency contact relationship to patient

Medical Insurance

Medical Insurance Carrier

Address

City / State / Zip

Medical Insurance Carrier Phone

Medical Insurance Carrier Employer Name

Medical Insurance Carrier Subscriber Name

Medical Insurance Carrier Subscriber ID #

Medical Insurance Carrier Subscriber Birthdate

Medical Questionnaire

Family Physician

Phone

Are you currently under care of a Physician ?

If Yes, what is the condition being treated ?

Have you had any serious illness, operation or been hospitalized within the past 5 years ?

If Yes, what illness or problem ?

Are you currently taking any medication ?

If Yes, what ?

Have you taken bisphosphonates (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast)

Have you ever taken the diet control drug Fen-Phen ?

Do you use alcoholic beverages ?

Do you smoke ?

Women Only

Are you pregnant?

If Yes, what is your due date ?

Are you currently nursing ?

Do you have menstrual period problems ?	
Are you on hormone replacement therapy ?	
Are you on birth control pills / fertility drugs ?	
Additional Comments	
Any Disease, Condition or Problem not Listed ? Please list	

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature **Date**

Dentist Signature **Date**