WELCOME TO RIVERSIDE DENTAL

Patient Information

Patient Name: _____ Date: _____
Last First MI

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

Birth Date: ____/____/____ Do you have dental insurance? _____
Day Month Year

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

Email address: _____ Place of Employment _____

Address: _____
Street Apartment #

_____
City Province Postal Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever 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
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Smoking Habit
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Thyroid Disease
☐ TMJ
☐ Tumors
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ _____
☐ _____

- Are you currently taking any Medications?
  Please List: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now currently 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: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Release of Personal Information

I authorize Dr. Vaidas Leskauskas and Dr. Sarune Leskauskas to consult with and/or send reports to medical and/or dental practitioners as it relates to dental treatment. I further authorize the release of appropriate personal information to dental plan providers electronically or otherwise, to permit reimbursement or predetermination of dental fees.

_____ Date:_____

Signature of patient, parent or guardian

Consent of Services

All dental services must be paid in full at the time of services. Accepted forms of payment include debit, credit card or cash.

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient. This office will help prepare the patients insurance forms or assist in making collections from insurance companies. However, this dental office cannot render services on the assumption that our charges will be paid by insurance company. OUR OFFICE DOES NOT ACCEPT DIRECT PAYMENT FROM DENTAL PLANS.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____

Signature of patient, parent or guardian

RIVERSIDE DENTAL OFFICE POLICIES

1.) Payment is required in full upon completion of every appointment.

2.) Acceptable forms of payment include cash, debit, Visa, and MasterCard. We do not accept Cheque or American Express.

3.) A missed appointment means loss of valuable time. A charge of $100 per appointment hour will apply unless twenty- four hours notice is given to change or cancel an appointment.

Please sign below to confirm you have read and understand our office policies. Should you have any questions or concerns, please do not hesitate to discuss them with Dr. Sarune Leskauskas or Dr. Vaidas Leskauskas.

Print Name: _____

Signature: _____

Date: _____