Cynthia A. Rider, D.M.D.
2545 Spring Arbor Road, Suite 202 • Jackson, Michigan 49203 • (517) 783-3130

Patient Data Record

Welcome to our office and thank you for selecting our dental healthcare team!
We strive to provide you with the best dental care.
Please fill out this form completely. If you have any questions or need assistance, please ask us.

Patient Information (please print)

Last Name:____________________ First Name:____________________ M.I.:______

Date of Birth:____________________ Soc Sec #:____________________

Street Address:____

City:____________________ State:__________ Zip Code:__________

Home Phone:____________________ Cell/Contact Phone:____________________

Employer:____________________ Work Phone:____________________

Driver's License #:____

Sex: ____ Male ____ Female Marital Status: ____ Single ____Married ____ Widowed ____Divorced

Primary Care Dentist:____________________ Primary Care Physician:____________________

Whom may we thank for the referral?____

Emergency Contact:____________________ Phone:________________Relationship:____________

If patient is under 18 Parent/Guardian Name:____

Phone:____________________ Relationship:____________________

Email:____

Our office does not accept secondary insurance. You are responsible for your entire co-pay at the time of your visit. We will be happy to be of assistance to you by providing you with a copy of the appropriate documentation for you to submit to your secondary insurance. Their payment will come directly to you.

Insurance Information

Insurance (Dental):

Employer Name____________________

Insurance Name:____________________

Subscriber Name:____________________

Subscriber SSN:____________________

Subscriber DOB:____________________

Subscriber Relationship to Patient:____________________

Insurance (Medical):

Employer Name____________________

Insurance Name:____________________

Subscriber Name:____________________

Subscriber SSN:____________________

Subscriber DOB:____________________

Subscriber Relationship to Patient:____________________

Secondary Dental Insurance: Yes or No Subscriber Name:____________________DOB:________SSN____________

Method of Payment

I understand that I am financially responsible for all charges, and accept responsibility for payment for any service provided to me that is not covered by my insurance. If this practice does not participate with my insurances, I also accept responsibility for fees that exceed the payment made by my insurance. I agree to pay all estimated co-pays at the time services are rendered. There will be a service charge of 1.5% per month on all unpaid balances over 60 days old.

____________________ ____________________

Date Patient/Parent/Guardian Signature

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Patient/Parent/Guardian Signature

RIDER ORAL SURGERY
rideroralsurgery.com

MEDICAL HISTORY

Name ______________________________ Date ____________ Age ____________

Physician ______________________________ Dentist ______________________________

	YES	NO
1. Are you under medical treatment now?	Y	N
2. Have you been hospitalized within the last 5 years?	Y	N
Please explain ______________________________		
3. Are you taking any medications?	Y	N
Please List ______________________________		
4. Do you smoke or chew tobacco?	Y	N
5. Do you use controlled substances?	Y	N
6. Do you wear contact lens?	Y	N
7. Have you ever had excessive bleeding from a tooth extraction?	Y	N

	YES	NO
8. Have you ever taken any of the following meds OR any medication for brittle bones or cancer; Bisphoshonate (i.e. Didronel, Skelid, Fosamax, Boniva, Actonel, Zometa Aredia, Reclast)	Y	N
9. Are you allergic to or have you had any Reactions to the following?		
Local anesthetics (e.g. novocaine)	Y	N
Penicillin or any other Antibiotics	Y	N
Other (please explain) ______________________________		
10. Women Only:		
Are you pregnant?	Y	N
Are you nursing?	Y	N
Are you taking Oral Contraceptives?	Y	N

Do you have any of the following?

	YES	NO		YES	NO		YES	NO
High Blood Pressure	Y	N	Asthma	Y	N	Anemia	Y	N
Heart Murmur	Y	N	Emphysema	Y	N	Cancer	Y	N
Heart Disease/Heart Attack Cardiac Stent	Y	N	Hay Fever/ Allergies	Y	N	Leukemia	Y	N
Rheumatic or Scarlet Fever	Y	N	Tuberculosis	Y	N	Radiation Therapy	Y	N
Chest Pain	Y	N	Kidney Disease	Y	N	Arthritis	Y	N
Cardiac Pacemaker	Y	N	Liver Disease	Y	N	Joint Replacement or Implant	Y	N
Mitral Valve Prolapse	Y	N	Diabetes	Y	N	Glaucoma	Y	N
Stroke	Y	N	Hepatitis/Jaundice	Y	N	AIDS or HIV infection	Y	N
Low Blood Pressure	Y	N	Fainting/Seizures	Y	N	Sexually Transmitted Disease	Y	N
Thyroid Problems	Y	N	Epilepsy/Convulsions	Y	N	Stomach Ulcers	Y	N
Psychiatric Care	Y	N	Alzheimer's	Y	N	Dementia	Y	N

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment or all services rendered on my behalf or my dependents.

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Signature of Patient (or Parent if Patient is a minor)