PATIENT INFORMATION

DATE: ☐NEW PATIENT ☐UPDATE

PATIENT:

LAST FIRST MI PREFERRED

☐MALE ☐FEMALE ☐STUDENT SCHOOL: ☐SINGLE ☐MARRIED ☐DIVORCED ☐OTHER:

PATIENT DATE OF BIRTH: **PATIENT SSN:**

ADDRESS:

ADDRESS LINE 1

HOME:

ADDRESS LINE 2

CELL :

WORK: EXT:

CITY ST ZIP CODE

E-MAIL:

WHOM MAY WE THANK FOR REFERRING YOU?

*IF CHILD, PROVIDE PARENT/GUARDIAN INFORMATION:

PARENT/GUARDIAN NAME(S): DATE OF BIRTH: SSN:

ADDRESS: PHONE:

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, PLEASE PROVIDE INFORMATION FOR THE NEAREST RELATIVE OR DESIGNATED CONTACT PERSON NOT AT THE PATIENT'S ADDRESS:

NAME RELATIONSHIP TELEPHONE

EMPLOYMENT INFORMATION (IF MINOR, PARENT/GUARDIAN INFORMATION)

Employer: Occupation:

Address:

ADDRESS LINE 1 WORK PHONE: ext:

ADDRESS LINE 2 CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY SUBSCRIBER: PRIMARY INSURANCE CARRIER:

LAST FIRST

SUBSCRIBER DATE OF BIRTH: ID NUMBER:

SUBSCRIBER EMPLOYER: GROUP/POLICY NUMBER:

SUBSCRIBER SSN: TELEPHONE NUMBER:

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER:

PRIMARY SUBSCRIBER: PRIMARY INSURANCE CARRIER:

LAST FIRST

SUBSCRIBER DATE OF BIRTH: ID NUMBER:

SUBSCRIBER EMPLOYER: GROUP/POLICY NUMBER:

SUBSCRIBER SSN: TELEPHONE NUMBER:

PATIENT RELATIONSHIP TO SUBSCRIBER: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER:

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE MY INSURANCE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE. I ALSO AUTHORIZE RIDGE VIEW DENTAL OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIMS.

PATIENT/GUARDIAN SIGNATURE DATE

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN: TELEPHONE:

CLINIC/FACILITY

MEDICAL HISTORY

GENERAL HEALTH : ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

☐Y☐N HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS?
IF SO, FOR WHAT REASON?

☐Y☐N USE TOBACCO IN ANY FORM? IF YES, TYPE:

☐Y☐N DOES YOUR PHYSICIAN (DOCTOR) REQUIRE YOU TO PRE-MEDICATE PRIOR TO DENTAL PROCEDURES?

FEMALE PATIENTS: ☐Y☐N CURRENTLY NURSING? ☐Y☐N CURRENTLY PREGNANT? DUE DATE:

DO YOU KNOW OF ANY REASON WHY ROUTINE DENTAL PROCEDURES MIGHT POSE A RISK TO YOU, OUR STAFF, OR OTHER PATIENTS? ☐Y☐N
IF YES, PLEASE DESCRIBE:

THERE ANYTHING IMPORTANT ABOUT YOUR MEDICAL CONDITION WE HAVE NOT ASKED? ☐Y☐N
IF YES, PLEASE DESCRIBE:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ FREQUENT HEADACHES
☐ANXIETY DISORDER
☐AUTISM/ASPERGER'S
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐ARTIFICIAL HEART VALVE
☐ GLAUCOMA
☐ FOOD ALLERGIES:
☐ANOREXIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐DRUG ADDICTION/ALCOHOLISM
☐CHICKEN POX
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐PACEMAKER
☐COLD SORES/FEVER BLISTERS
☐BULIMIA
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER DISEASE
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐BLEEDING DISORDER
☐HEARING PROBLEMS
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS
☐STD
☐FREQUENT EAR INFECTIONS
☐OTHER – PLEASE LIST:

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐OTHER – PLEASE LIST:
☐CODEINE
☐LATEX
☐NITROUS OXIDE SEDATION
☐METAL SENSITIVITY
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐TRANQUILIZERS
☐OTHER (PLEASE LIST)
☐ORAL/IV BISPHORATES (OSTEOPOROSIS, PAGET'S DISEASE)

☐Y☐N ARE YOU TAKING ANY PRESCRIPTION OR DAILY OVER THE COUNTER MEDICATIONS/DRUGS? *IF YES, LIST BELOW:*

DRUG NAME	DOSAGE	REASON PRESCRIBED

PREVIOUS DENTIST INFORMATION

DENTIST: ______________________ TELEPHONE: ______________________

CLINIC NAME/CITY: ______________________

REASON FOR CHANGING: ______________________

DENTAL HISTORY

DATE OF LAST DENTAL VISIT:

HOW OFTEN DO YOU BRUSH YOUR TEETH? FLOSS?

DO YOUR GUMS BLEED? WHEN? ☐ BRUSHING ☐ FLOSSING ☐ OTHER:

- ☐Y☐N I AM UNCOMFORTABLE SHOWING MY TEETH WHEN I SMILE.
- ☐Y☐N I AM UNHAPPY WITH MY CROWNS OR FILLINGS.
- ☐Y☐N MY GUMS OR TEETH ARE SENSITIVE
- ☐Y☐N I AM CONCERNED THAT MY GUMS ARE RECEDING
- ☐Y☐N I CLENCH OR GRIND MY TEETH
- ☐Y☐N I HAVE QUESTIONS ABOUT THE BENEFITS OF DENTAL IMPLANTS

- ☐Y☐N I AM UNHAPPY WITH THE APPEARANCE OF MY TEETH
- ☐Y☐N I FEEL THAT MY TEETH COULD BE WHITER
- ☐Y☐N I AM INTERESTED IN STRAIGHTENING MY TEETH
- ☐Y☐N I FEEL MY TEETH ARE TOO LONG OR TOO SHORT
- ☐Y☐N I AM ANXIOUS OR FEARFUL OF TREATMENT.
- ☐Y☐N IS THERE SOMETHING ELSE HOLDING YOU BACK FROM THE PERFECT SMILE? (EXPLAIN BELOW)

THE MOST IMPORTANT CONCERNS REGARDING MY DENTAL TREATMENT ARE:

WHAT FACTORS ARE MOST IMPORTANT FOR YOUR SATISFACTION WITH OUR OFFICE?

ANY ADDITIONAL CONCERNS/COMMENTS?

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IF CHILD/MINOR: PLEASE ANSWER THE FOLLOWING QUESTIONS:

- ☐Y☐N ANY MOUTH HABITS? (THUMB SUCKING, TONGUE THRUSTING, NAIL BITING, MOUTH BREATHING, NURSING/BOTTLE HABITS, PACIFIER, ETC.) ______________________
- ☐Y☐N DO YOU HELP YOUR CHILD WITH BRUSHING AND FLOSSING? IF YES, HOW OFTEN? ______________________

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT AND CONSENT TO PROCEED: I CERTIFY THAT THE ANSWERS TO THE HEALTH QUESTIONS ARE ACCURATE AND CORRECT TO THE BEST OF MY KNOWLEDGE. SINCE A CHANGE OF MEDICAL CONDITION OR MEDICATIONS CAN AFFECT DENTAL TREATMENT, I UNDERSTAND THE IMPORTANCE OF AND AGREE TO NOTIFY THE DENTIST OF ANY CHANGES AT ANY SUBSEQUENT APPOINTMENT. I UNDERSTAND THAT THE ADMINISTRATION OF LOCAL ANESTHETIC MAY CAUSE AN UNTOWARD REACTION OR SIDE EFFECTS, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO BRUISING, HEMATOMA, CARDIAC STIMULATION, TEMPORARY OR RARELY, PERMANENT NUMBNESS, AND MUSCLE SORENESS. I UNDERSTAND THAT AS A RESULT OF DENTAL TREATMENT, INCLUDING PREVENTATIVE PROCEDURES SUCH AS CLEANING AND BASIC DENTISTRY, AS WELL AS FILLINGS OF ALL TYPES, TEETH MAY REMAIN SENSITIVE OR EVEN POSSIBLY QUITE PAINFUL BOTH DURING AND AFTER COMPLETION OF TREATMENT. GUMS AND SURROUNDING TISSUES MAY ALSO BE SENSITIVE OR PAINFUL DURING AND OR AFTER TREATMENT.

CONSENT FOR TREATMENT: I HERBY GRANT AUTHORITY TO THE DENTIST AT RIDGE VIEW DENTAL TO ADMINISTER ANY TREATMENT OR TO ADMINISTER SUCH ANESTHETICS, ANALGESICS, SEDATIVES AND NITROUS OXIDE SEDATION, AND TO PERFORM SUCH OPERATIONS AS MAY BE DEEMED NECESSARY OR ADVISABLE IN MY DIAGNOSIS AND TREATMENT. I HAVE READ THE ABOVE TERMS AND CONDITIONS AND CONSENT FOR TREATMENT AND FULLY AGREE TO THEIR CONTENT. I DO VOLUNTARILY ASSUME ANY AND ALL POSSIBLE RISKS, INCLUDING THE RISK OF SUBSTANTIAL AND SERIOUS HARM, IF ANY, WHICH MAY BE ASSOCIATED WITH GENERAL PREVENTATIVE AND OPERATIVE TREATMENT PROCEDURES IN HOPES OF OBTAINING THE POTENTIAL DESIRED RESULTS, WHICH MAY OR MAY NOT BE ACHIEVED, FOR MY BENEFIT.

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SIGNATURE OF PATIENT/GUARDIAN DATE RELATIONSHIP TO PATIENT

FINANCIAL & TRUTH-IN-LENDING

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE POSSIBLE TO ACHIEVE TOTAL ORAL HEALTH. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE AND YOUR UNDERSTANDING OF OUR FINANCIAL GUIDELINES.

FINANCIAL

- AS A CONDITION OF YOUR TREATMENT BY THIS OFFICE, FINANCIAL ARRANGEMENTS MUST BE MADE IN ADVANCE. THIS PRACTICE DEPENDS UPON REIMBURSEMENT FROM OUR PATIENTS FOR THE COSTS INCURRED IN THEIR CARE TO REMAIN VIABLE. THEREFORE, FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT.
- ALL EMERGENCY DENTAL SERVICES, OR DENTAL SERVICES PERFORMED WITHOUT PREVIOUS FINANCIAL ARRANGEMENTS, MUST BE PAID FOR, IN FULL, AT THE TIME THE SERVICES ARE RENDERED.
- I AGREE TO PAY A $35.00 FEE ON ALL RETURNED OR CANCELLED CHECKS.
- I UNDERSTAND WE OFFER A 10% DISCOUNT FOR THE UNINSURED ONLY IF FULL PAYMENT IS MADE PRIOR TO APPOINTMENT.
- I AGREE TO PAY 1.75% PER MONTH (21% ANNUAL) ON ANY UNPAID BALANCE PAST DUE 60 DAYS.
- I UNDERSTAND THERE IS A NO SHOW/CANCELLATION FEE FOR ALL APPOINTMENTS. THE FEE IS $50 AND WILL BE CHARGED PER HOUR OF TIME SCHEDULED. **PLEASE GIVE 48 HOURS NOTICE** IF YOU ARE UNABLE TO KEEP YOUR RESERVED TIME.
- I AGREE THAT FAILURE TO MAKE A PAYMENT OR TO CONTACT US FOR THREE CONSECUTIVE MONTHS WILL RESULT IN MY ACCOUNT BEING REFERRED TO OUR COLLECTION ATTORNEY. ALL PAYMENT ARRANGEMENTS MUST THEN BE MADE WITH THEM. ALL COLLECTION FEES WILL BE ADDED TO BALANCE.
- IN THE EVENT MY ACCOUNT IS NOT PAID AS AGREED, I AGREE TO PAY A COLLECTION FEE OF 40% OF MY OUTSTANDING BALANCE IN ADDITION TO MY BALANCE. ADDITIONAL COLLECTION AGENCY FEES, ATTORNEY'S FEES AND COURT COSTS WILL BE ADDED.

INSURANCE

- I UNDERSTAND THAT MY INSURANCE IS A CONTRACT BETWEEN MYSELF AND THE INSURANCE COMPANY, AND I UNDERSTAND THE PATIENT OR RESPONSIBLE PERSON IS ULTIMATELY RESPONSIBLE FOR ALL CHARGES NOT PAID BY THE INSURANCE COMPANY.
- I UNDERSTAND THAT MY INSURANCE CLAIM WILL BE FILED BY THE DENTAL OFFICE AS A COURTESY TO THE PATIENT. ANY UNPAID CLAIMS WILL NEED TO BE RESOLVED WITHIN 60 DAYS. ALL UNPAID BALANCES PAST 60 DAYS WILL BE CHARGED 1.75% INTEREST.
- I UNDERSTAND THAT NOT ALL DENTAL SERVICES MAY BE COVERED IN THE CONTRACT, AND THAT SOME INSURANCE COMPANIES ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER.
- I UNDERSTAND THAT HAVING DOUBLE COVERAGE DOES NOT ALWAYS GUARANTEE PAYMENT FROM BOTH INSURANCES. IT IS POSSIBLE THE SECONDARY INSURANCE WILL HAVE EXCLUSIONS OR WILL NOT PAY AT ALL.
- I UNDERSTAND THE QUOTED CO-PAYMENT IS JUST AN ESTIMATE ON OUR EXPERIENCE. PLEASE UNDERSTAND THAT EACH INSURANCE COMPANY HAS MULTIPLE FEE AND BENEFIT SCHEDULES AND IT IS IMPOSSIBLE FOR US TO KNOW JUST WHICH PLAN YOUR EMPLOYER HAS CHOSEN, NOR IS IT POSSIBLE FOR OUR OFFICE TO CATALOG EVERY BENEFIT PLAN FROM EVERY POSSIBLE EMPLOYER.

PAYMENTS

- **PATIENT PORTION OR PATIENT CO-PAY IS DUE AT THE TIME SERVICES ARE RENDERED** – UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.
  PAYMENT INFORMATION
  - ALL MAJOR CREDIT CARDS ARE ACCEPTED (VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS)
    - 10% DISCOUNT FOR OUR UNINSURED CASH/CHECK PAYING PATIENTS.
    - FINANCING OPTIONS WITH CARECREDIT®
- BALANCES LEFT OVER 60 DAYS WILL INCUR 1.75% MONTHLY (21% ANNUALLY)/ WE REALIZE THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS DO ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANT IN THE MANAGEMENT OF YOUR ACCOUNT.

PATIENT CONSENT – PAYMENT AUTHORIZATION – SIGNATURE ON FILE

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH STATUS OR IF MY MEDICATIONS CHANGE, I SHALL INFORM THE DENTIST AND STAFF AT THE NEXT APPOINTMENT WITHOUT FAIL.

I HERBY AUTHORIZE PAYMENT DIRECTLY TO RIDGE VIEW DENTAL OF THE DENTAL BENEFITS OTHERWISE PAYABLE TO ME.

I HERBY AUTHORIZE RIDGE VIEW DENTAL TO RELEASE ANY INFORMATION CONCERNING MY HEALTH OR DENTAL CARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED. THIS INFORMATION IS TO BE USED IN ADMINISTERING DENTAL CLAIMS AND/OR DISCUSSING TREATMENT OPTIONS WITH OTHER DENTAL PROFESSIONALS.
I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE STATEMENTS MENTIONED ABOVE.

Signature: Date:

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

MY SIGNATURE CONFIRMS THAT I HAVE BEEN INFORMED OF MY RIGHTS TO PRIVACY REGARDING MY PROTECTED PERSONAL AND HEALTH INFORMATION, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPA). I UNDERSTAND THE TERMS IN WHICH MY PERSONAL HEALTH AND IDENTIFICATION INFORMATION MAY BE USED.

I HAVE BEEN INFORMED OF MY DENTAL PROVIDER'S *NOTICE OF PRIVACY PRACTICES* CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION. I HAVE BEEN GIVEN THE RIGHT TO REVIEW AND RECEIVE A COPY OF SUCH *NOTICE OF PRIVACY PRACTICES.* I UNDERSTAND THAT MY DENTAL PROVIDER HAS THE RIGHT TO CHANGE *THE NOTICE OF PRIVACY PRACTICES* AND THAT I MAY CONTACT THIS OFFICE TO OBTAIN A CURRENT COPY OF THE *NOTICE OF PRIVACY PRACTICES*.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS AND I UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

SIGNATURE: **Date:**

RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT ☐GUARDIAN

I GIVE PERMISSION FOR THE FOLLOWING COMMUNICATIONS TO BE USED BY RIDGE VIEW DENTAL (PLEASE CHECK ALL THAT APPLY):

☐ CELL PHONE
☐ TEXT MESSAGE REMINDERS
☐ HOME PHONE
☐ WORK PHONE
☐ E-MAIL

☐ I AM GRANTING PERMISSION FOR RIDGE VIEW DENTAL TO DISCLOSE THEIR IDENTIY TO ANYONE WHO MAY ANSWER MY HOME, WORK, OR CELL PHONE.
☐ I AM GRANTING PERMISSION FOR RIDGE VIEW DENTAL TO LEAVE A MESSAGE WITH ANY PERSON WHO MAY ANSWER MY PHONE OR MY VOICEMAIL OF THE FOLLOWING NUMBERS (PLEASE CHECK ALL THAT APPLY):
☐ HOME PHONE
☐ CELL PHONE
☐ WORK PHONE
☐ NONE- PLEASE JUST ASK FOR A CALL BACK
☐ OTHER (PLEASE EXPLAIN):

I WOULD LIKE TO GIVE PERMISSION FOR THE FOLLOWING PERSON(S) TO HAVE ACCESS TO PERSONAL INFORMATION INCLUDING BUT NOT LIMITED TO APPOINTMENTS, TREATMENT, AND BILLING OF MYSELF AND ANY DEPENDENT CHILDREN.

FOR OFFICE USE ONLY:

WE WERE UNABLE TO OBTAIN THE PATIENT'S WRITTEN ACKNOWLEDGEMENT OF OUR *NOTICE OF PRIVACY PRACTICES* DUE TO THE FOLLOWING REASON:

☐ THE PATIENT REFUSED TO SIGN
☐ COMMUNICATION BARRIERS
☐ EMERGENCY SITUATION
☐ OTHER – PLEASE LIST: