Chart#:_____

Patient Information

Please take a moment to enter your information to help us ensure the quality of your care excellent.

Patient Name: Last_____First_____MI_____Preferred Name_____

Title: (Mr/Mrs/Ms) _____ Gender: Male__ Female__ Family Status: Married__ Single__ Child__ Other__

Birth Date: _____ Social Security #: _____ Email Address: _____

Phone: Home_____ Work_____ Ext____ Mobile_____

Best time to call:_____ Best way to reach you: Phone___ Text___ Email___

Address: _____City_____State___Zip Code_____

If student, School Attending: _____

Preferred appointment times:

Mon___ Tue___ Wed___ Thu___ Fri___ Sat___ Morning___ Afternoon___ Evening___ Any time___

Whom may we thank for referring you to our practice?

Dental Office___ Newspaper___ Yellow Pages___ Internet___ School___ Work___ Other_____

Responsible Party Information

The following is for: the patient__ the patient's spouse__ the patient's parent__

Name: Last_____First_____MI_____Preferred Name_____

Title: (Mr/Mrs/Ms) _____ Gender: Male__ Female__ Family Status: Married__ Single__ Child__ Other__

Birth Date: _____ Social Security #: _____ Email Address: _____

Phone: Home_____ Work_____ Ext____ Mobile_____

Address: _____City_____State___Zip Code_____

Employment Information

The following is for: the patient___ the person responsible for payment___

Employer Name: _____ Occupation: _____ Phone: _____

Address: _____City_____State___Zip Code_____

Insurance Information

	Primary insurance	Secondary Insurance
Insurance Company Name		
Employee		
ID # / Group #		
Employee Social Security #		
Employee Birth Date		

FINANCIAL AGREEMENT

Thank you for choosing Ridge Family Dental. Our primary mission is to improve patients' dental health as well as their overall health using only the best material and technology available in the market today. We pride ourselves in providing the highest quality of dental care in a pleasant and compassionate environment. An important part of the mission is making the cost of optimal dental care as easy and manageable for our patients as possible by offering a wide range of payment options.

Financial options to pay for your treatment:

A. Prepayment in Full: For any treatment over $2000, a prepayment Bookkeeping Courtesy of 5% will be given for direct payment in full by cash or check before or at first treatment visit.

B. Pay as You Go: You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C. Split Payment: Half of the total treatment is due at the preparation visit, and the second half is due the day of cementation of the crowns/bridges/veneers.

D. CareCredit – Convenient Low Monthly Payments

With fast online approval CareCredit can help you get the healthy, radiant smile you've always wanted with the card designed specifically for your dental needs. CareCredit offers No Interest and low monthly payment options, no up-front costs, no prepayment penalties, and no annual fees so you can show off those pearly whites as soon as you are ready.

FORMS OF PAYMENT ON BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following: Cash, Visa, MasterCard, Discover, Money Order, Personal Check, or CareCredit (see above).

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and minimize your out of pocket payment. We directly bill your dental insurance for reimbursement for your dental services rendered at Ridge Family Dental. After your dental insurance has paid for dental services, you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe, however, if we do not receive payment from your insurance within 30 days, you will be responsible for your balance.

Payment is due within thirty (30) days of billing. If not paid accordingly, interest at 1½ percent per month will be added. If any balances with any interest is not paid and the matter is referred for collection, I acknowledge that attorney fees incurred to collect on this account will be added to the balance due that is a reasonable fee.

There is a $50 fee for cancellations or broken appointments without 48 hour notice.
Returned checks will be subject to $30 fee.

Please do not hesitate to ask if you have any questions regarding this financial agreement.
I certify that I have read, fully understand, and accept the following financial policy.

_____	_____	_____
Print Name of Patient or Responsible Party	Signature	Date

Medical and Dental History Form

Patient Name: Last_____First_____MI_____Preferred Name_____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? Yes___ No___

Within the past year, have there been any changes in your general health? Yes___ No___

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's: Name _____Address _____Phone #_____

Please mark any of the following to indicate YES in response to the question:

___Have you ever had complications following dental treatment? _____

___ Are you currently under the care of a physician due to a specific condition? _____

___ Have you been hospitalized within the last 5 years due to surgery or illness? _____

___ Are you currently taking any prescription or non-prescription medication? _____

___ Do you often feel tired, fatigued, or sleeping during daytime?

___ Do you use tobacco (smoking or chewing)?

___ Do you require the use of corrective lenses (contacts or glasses)?

___ Do you have any conditions, diseases, etc., not listed above that we should be aware of? _____

If any of the previous questions are marked, please explain:

_____

Women only:

Are you pregnant? Yes___ No___ Due Date: _____ OB/GYN: Name _____ Phone # _____

Please indicate if you have experienced any of the following:

__ Pre-Med - Amoxicillin	**__ Pre-Med - Clindamycin**	**__ Pre-Med - Other**	**__ Allergy – Penicillin**
__Allergy – Aspirin	__ Allergy – Codeine	__ Allergy – Erythromycin	__ Allergy – Hay Fever
__ Allergy – Latex	__ Allergy – Other	__Allergy – Sulfa	__Anemia
__ Arthritis	__Artificial Joints	__ Asthma	__Blood Disease
__ Cancer	__ Diabetes	__ Dizziness	__Epilepsy
__ Excessive Bleeding	__ Fainting	__ Glaucoma	__ Head Injuries
__ Heart Disease	__ Heart Murmur	__ Hepatitis	__ High Blood Pressure
__HIV	__ Jaundice	__ Kidney Disease	__ Liver Disease
__Mental Disorders	__ Nervous Disorders	__Pacemaker	__ Radiation Treatment
__ Respiratory Problems	__ Rheumatic Fever	__ Rheumatism	__ Sinus Problems
__ Stomach Problems	__ Stroke	__ Tuberculosis	__ Tumors
__ Ulcers	__ Venereal Disease	__Thyroid Problems	__ Eating Disorders
__ Acid Reflux	__ Chemical Dependency	__ Sleep Apnea/Snoring	

Do you have any other health issues or allergies? _____

What is the reason for your dental visit today? _____

When was your last visit to the dentist? _____

What was done on your last dental visit? _____

Prior Dentist's name, address, phone number: _____

Have you ever had any serious problem associated with previous dental treatment? _____

_____

What, if anything, has happened in previous experiences at the dentist that was reason not to return? _____
_____

How frequently do you brush your teeth? __3(+) a day __twice a day __once a day __weekly __seldom

How frequently do you floss your teeth? __1(+) a day __2-6 weekly __1-6 monthly __seldom __never

Please mark any of the following to indicate YES in response to the question:

___ Do your gums bleed when you brush or floss?
___ Do your teeth experience sensitivity to cold or hot temperatures?
___ Are any of your teeth currently causing you pain?
___ Do you grind your teeth (either consciously or during sleep)?
___ Does food catch between your teeth?
___ Do you experience dry mouth?
___ Do you experience clicking/popping jaw, jaw pain, or jaw tenderness?
___ Are any of your teeth loose, or are you concerned about any teeth loosening?
___ Do you currently have dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

Dietary Habits

Do you consume any of the following drinks? How many per day?

___ sweet tea ___ regular soda ___ diet soda ___ sport drinks ___ juice ___ energy drinks ___ other

Do you chew gum? How often? ___ sugar free ___ regular

Do you consume hard candy or mints? ___ yes ___ no How often? _____

Are there any other dietary habits you would like to make us aware of? _____

_____ (initial) To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

Thank you for choosing Ridge Family Dental. We pride ourselves in providing the highest quality of dental care in a pleasant and compassionate environment. Our commitment is to our patients and their health, happiness, and total body well-being.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing inaccurate information has the potential of being hazardous to my health. The undersigned hereby authorizes the Doctor and staff to take study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with (name of patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. By signing below I acknowledge receipt of Ridge Family Dental Notice of Privacy Practices. I hereby give consent to Ridge Family Dental to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations by any method, including electronic transfer. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for payment for dental services provided in this office for myself or my dependents and due and payable at the time of service.

Print Name of Patient (or parent/guardian if minor): _____

Signature of Patient (or parent/guardian if minor): _____

Date:_____

Reviewed By Doctor: _____ Date:_____

History Review and Significant Findings: _____

_____

_____

_____

_____

_____

_____

_____