

PLEASE PRINT - IN INK

PATIENT REGISTRATION - ADULT

PATIENT'S NAME _____
(FIRST) (M.I.) (LAST)

WHAT DO YOU PREFER WE CALL YOU? _____

ADDRESS _____
(STREET) (CITY, STATE, ZIP CODE)

HOW LONG AT THIS ADDRESS? _____ HOME PHONE () _____

AGE _____ DATE OF BIRTH _____ SEX _____ CELL PHONE () _____

SOCIAL SECURITY NUMBER _____ DRIVER'S LICENSE NUMBER _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE () _____
(Street) (City) (State) (Zip)

HOW LONG EMPLOYED _____ E-MAIL ADDRESS _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE () _____
(Street) (City) (State) (Zip)

SPOUSE'S SOC. SEC. NO. _____ DRIVER'S LICENSE NO. _____

HOW LONG EMPLOYED _____ SPOUSE'S BIRTHDATE _____

PREVIOUS ADDRESS (IF LESS THAN 3 YEARS) _____

(CITY) (STATE) (ZIP)

NAME/ADDRESS OF NEAREST FRIEND OR RELATIVE WHO CAN BE REACHED IN AN EMERGENCY:

(Name) (Street) (City) (State) (Zip) (Phone)

RELATIONSHIP TO PATIENT _____

IS PATIENT COVERED BY DENTAL INSURANCE? YES NO

INSURANCE CO. _____ INSURANCE CO. _____

SUBSCRIBER NAME _____ SUBSCRIBER NAME _____

EMPLOYER NAME _____ EMPLOYER NAME _____

ID/GROUP NO. _____ ID/GROUP NO. _____

METHOD OF PAYMENT: CASH CHECK CREDIT CARD (MASTERCARD/VISA)

SIGNATURE OF PATIENT _____ DATE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

SINGLE	<input type="checkbox"/>
MARRIED	<input type="checkbox"/>
WIDOWED	<input type="checkbox"/>
DIVORCED	<input type="checkbox"/>
SEPARATED	<input type="checkbox"/>

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Age _____

Please answer the following questions below by checking the YES or NO box.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you currently under medical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| In yes, please explain. _____ | | |
| 3. Have you ever been hospitalized or had a serious illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | |
| 4. Have you ever had excessive bleeding following an extraction, or had other bleeding problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. (WOMEN) Are you pregnant? If yes, give due date | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use tobacco in any form? If yes, how much? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use alcoholic beverages (more than 2 drinks per day)? | <input type="checkbox"/> | <input type="checkbox"/> |

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING ...

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> | Persistent, lingering or prolonged fevers | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attacks | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A B C (please circle) | <input type="checkbox"/> | <input type="checkbox"/> |
| Stents ____ Valve Replacement ____ | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis ____ or Rheumatism ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions ____ or Epilepsy ____ | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Condition ____ or Goiter ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Asthma ____ or Hay Fever ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Nights Sweats | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue, tiredness, or weakness within the past two years | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any artificial joints? If yes, where _____ Pre Med Required? | <input type="checkbox"/> | <input type="checkbox"/> |

ARE YOU ALLERGIC OR HAVE YOU EVER EXPERIENCED ANY REACTION TO THE FOLLOWING ...

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|
| Local Anesthetics (Like Novocaine) | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin ____ or Codeine ____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates / Sedatives / Sleeping Pills | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Latex | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Antibiotics _____ | <input type="checkbox"/> | <input type="checkbox"/> | Other Allergies _____ | <input type="checkbox"/> | <input type="checkbox"/> |

ARE YOU TAKING ANY OF THE FOLLOWING ...

- | | YES | NO | | YES | NO |
|---------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Antibiotics / Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> | Tranquilizers | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Thinners | <input type="checkbox"/> | <input type="checkbox"/> | Insulin / Diabetic Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Pressure Medication | <input type="checkbox"/> | <input type="checkbox"/> | Recreational Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Medication | <input type="checkbox"/> | <input type="checkbox"/> | Digitalis / Other Heart Medication | <input type="checkbox"/> | <input type="checkbox"/> |
| Cortisone / Steroids | <input type="checkbox"/> | <input type="checkbox"/> | Nitroglycerin | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy Medications | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |

Other Medications (Please List) _____

List any other medical condition(s) or physical limitation we should be aware of _____

Physician's Name _____ Phone (____) _____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient, _____

Parent, or Guardian: _____ Date: _____

DENTAL HISTORY

Patient's Name _____ Date of Birth _____ Age _____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Bleeding, Sore Gums	<input type="checkbox"/>	<input type="checkbox"/>	Loose Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Unpleasant Taste / Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to heat, cold, sweets	<input type="checkbox"/>	<input type="checkbox"/>
Burning Tongue / Lips	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Blisters, Lip/Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Swelling / Lumps in Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Biting	<input type="checkbox"/>	<input type="checkbox"/>
Biting Cheeks / Lips	<input type="checkbox"/>	<input type="checkbox"/>	Clenching / Grinding	<input type="checkbox"/>	<input type="checkbox"/>
Clicking / Popping / Pain in Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Change of Bite	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic Treatments (Braces)	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal Treatment (Gum Surgery)	<input type="checkbox"/>	<input type="checkbox"/>
Dental Implants	<input type="checkbox"/>	<input type="checkbox"/>	Whitening	<input type="checkbox"/>	<input type="checkbox"/>

Date of Last Dental Visit _____

DO YOU USE THE FOLLOWING:

	YES	NO	
Brush	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____
Dental Floss	<input type="checkbox"/>	<input type="checkbox"/>	Brush is Soft ____ Medium ____ Hard ____
Fluoride Rinses	<input type="checkbox"/>	<input type="checkbox"/>	

DO YOU LIKE THE APPEARANCE OF YOUR SMILE? YES NO If not, why _____

WHAT ARE YOUR OTHER DENTAL CONCERNS? _____

TO BE FILLED OUT FOR CHILDREN 12 YEARS OF AGE OR YOUNGER:

	YES	NO
Is this your first dental visit?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been unpleasant medical or dental visits?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a finger sucking habit?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any injuries to the mouth / teeth / head?	<input type="checkbox"/>	<input type="checkbox"/>
Have there been fluoride treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Does your child brush daily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you assist your child with tooth brushing	<input type="checkbox"/>	<input type="checkbox"/>
How often? _____		
Do you desire complete dental service for the child?	<input type="checkbox"/>	<input type="checkbox"/>

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.

Signature of Patient,
Parent, or Guardian: _____ Date: _____

Ridgewood Dental P.C.

7777 E. Ridge Road Suite A Hobart, IN 46342
(219) 947-2922 Fax (219) 942-1876

Financial Responsibility

I _____ (Responsible Party) agree, I am financially responsible for _____ (Patient's Name) dental treatment provided by Ridgewood Dental P.C. I also agree I am responsible for a monthly finance charge of 1.75% MPR, which will be added to balances more than 30 days old (\$10.00 minimum). If collection action is initiated on my account, I agree I am responsible for all fees, attorney fees and all court costs incurred by Ridgewood Dental P.C.

(Delinquent accounts may be reported to the credit bureau and may affect your credit rating).

Signed _____ Date _____

I give consent to Ridgewood Dental P.C. to send any necessary reminders concerning appointment or needed treatment.

Signed _____ Date _____

Insurance Authorization

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to:

RIDGEWOOD DENTAL P.C.

A copy of this can be considered an original for insurance purposes.

I acknowledge and understand I am responsible for all charges for all services rendered to me or any member of my family.

I further understand my insurance company may pay only usual and customary fees which are not acceptable to the doctor and therefore are my responsibility to pay.

Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid for by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed _____ Date _____

Ridgewood Dental P.C.

7777 E. Ridge Road Suite A Hobart, IN 46342
(219) 947-2922 Fax (219) 942-1876

Our practice is passionate about your dental health and takes pride in providing you with the best care possible. Our team will take time to discuss our professional fees and financial options with you that will allow you to make informed decisions regarding your dental treatment and select a financial arrangement that is affordable for you. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions, or concerns, please do not hesitate to ask.

Payment is due and payable at the time services are rendered. For your convenience, we accept Cash, Personal Checks (Indiana only), Visa, Master Card and Discover Card.

Payment Plans / Financial Arrangements

- **5% Courtesy** - You can take advantage of our courtesy if you pay your balance in full at time of service by cash only. This is extended to patients with no dental insurance.
- **10% Senior Courtesy** - You can take advantage of our senior courtesy if you pay your balance in full at time of service by cash only. This is extended to patients with no dental insurance at age 60.
- **No Interest Financing** - We now offer a financing option through CareCredit. This option offers no interest payment plans with affordable low monthly payments. Easy to apply online or by phone.
- An account service charge will be assessed each billing period on all balances 30 days past due (\$10.00 minimum).

Dental Insurance - If you have dental insurance to help you with your payment please submit a photocopy of your Insurance card and your dental benefits booklet, if available. We cannot bill your insurance company until we receive your insurance information. As a courtesy, we will process your insurance claim. However, we do require your estimated payment to be paid on the day of your visit. (Your deductible and/or co-payment). The balance incurred is your responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy and our office cannot guarantee the amount of coverage offered by your insurance carrier. Please understand your insurance policy is a contract between you and your insurance company. Any excess monies collected by our practice will be refunded to you once we receive the insurance check or in the case of an underpayment by your insurance company the remaining will be due within 30 days. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to: RIDGEWOOD DENTAL, P.C., I acknowledge and understand I am responsible for all changes for all services rendered to me or any member of my family. A copy of this can be considered an original for insurance purposes.

Broken Appointments - In our practice an appointment reserved by you is confirmation that you are committed to your treatment as our team of Doctors and Hygienists are committed to taking care of your treatment needs. We realize emergencies do arise, but repeated broken appointments will necessitate us to ask you to call the office on a day you are available to have treatment. Please note if you arrive after your scheduled appointment time, we will do our best to accommodate you.

Collection Policy - Collection action will be taken on any unpaid balance. If collection action is initiated on my account, I agree I am responsible for all fees, attorney fees and all court costs incurred by Ridgewood Dental P.C. Delinquent accounts may be reported to the credit bureau and may affect your credit rating.

I hereby acknowledge receipt of the above payment options and financial responsibilities.

Print Name _____

Signature _____ Date _____



Phone: (219) 947-2922 Fax: (219) 942-1876
www.RidgewoodDentalCenter.com

Patient Consent for Use and Disclosure of PHI and NPP Receipt

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Ridgewood Dental P.C., in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information. The Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient. _____

_____ effective until (Date) _____

This Organization will utilize the patients address and telephone numbers for communications.

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

This Organization has published a HIPAA 'Notice of Privacy Practices' (NPP). I have been informed and provided a copy of the NPP. Please check one item below:

_____ NPP Provided

_____ NPP Previously Provided

_____ NPP Declined

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEIVED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Print Name

Patient or Legally Authorized Representative **Date** **Time**

Relationship to Patient If Signed By Another Party **Date** **Time**

Please explain Patient's Representative Relationship to the patient and include a description of the Representatives authority to act on behalf of the patient.

