RIDGE COMMONS
FAMILY DENTISTRY

Thank you for trusting us with your dental care.

Welcome to our family! So that we may better assist you, please fill out this form as completely as you can. If you have any questions, please let us know. We look forward to be your partner in maintaining your dental health.

PATIENT INFORMATION CONFIDENTIAL

Name _____ SSN/ID _____
First Middle Initial Last

Address _____ City _____ State _____ Zip _____

Home Phone (____)_____ Cell Phone (____)_____ Other Phone (____)_____

Email _____ Sex: □ M □ F Age _____ Birthdate _____

Please check appropriate box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Occupation _____ Spouse or Parent/Guardian's Name _____

Patient Employer/School _____ City _____ State _____ Zip _____

Person to contact in case of an emergency _____ Phone (____)_____

Pharmacy Name _____Phone (____)_____

Whom may we thank for referring you? _____

Would you like text or email reminder? □ Yes □ No

INSURANCE INFORMATION

Person Responsible for Account _____Relation to Patient_____
First Middle Initial Last

Birthdate _____ Social Security N _____ Phone Number (____)_____

Address (*if different from patient's*) _____ City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____ Customer Service Phone #_____

Insurance Address _____ Group # _____Insurance ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ Yes □ No IF YES, COMPLETE THE FOLLOWING:

Person Responsible for Account _____Relation to Patient_____
First Middle Initial Last

Birthdate _____ Social Security No. _____ Phone Number (____)_____

Address (*if different from patient's*) _____ City _____ State _____ Zip _____

Person Responsible Employed By _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____ Customer Service Phone #_____

Insurance Address _____ Group # _____Insurance ID # _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Reason for leaving _____

Check (✓) if you have had problems with any of the following:

- □ Bad breathe
- □ Bleeding gums
- □ Clicking or popping jaws
- □ Food collection between teeth
- □ Snore or have sleep apnea
- □ Teeth Grinding
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sensitivity to sweet, hot/cold, or biting
- □ Sores/growths in mouth
- □ Yellow or discolored teeth
- □ Dissatisfied with teeth/appearance
- □ Other

*(please specify)*_____

_____

How often do you floss? _____ How often do you brush? _____

Have your wisdom teeth been extracted? □ Yes □ No

Are you nervous about dental treatment? □ Yes □ No

MEDICAL INFORMATION

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □ Yes □ No

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe _____

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates _____

Do you have Poryphyria (blood disorder)? □ Yes □ No

Have you or anyone in your family had malignant hyperthermia or other complications while under general anesthesia? □ Yes □ No

Gender Specific Questions:
Are you pregnant or could be pregnant? □ Yes □ No
Are you Nursing? □ Yes □ No
Are you taking birth control pills? □ Yes □ No

Check (✓) if you have had problems with any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints
- □ Asthma
- □ Back Problems
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Cough up blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart murmur
- □ Heart Problems
- □ Hemophilia
- □ Hepatitis
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet/Ankle
- □ Thyroid Problems
- □ Tobacco Habits
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

Medications *(please list medications you are currently taking)*

_____

_____

Allergies *(please list if any)*

_____

_____

AUTHORIZATION

I understand that I am financially responsible for the payment of my account, not the insurance company. Ridge Commons Family Dentistry file dental and medical insurance claims as a courtesy to me. Ridge Commons Family Dentistry can only make estimates regarding my insurance benefits based on the information I provided above and by the insurance company. In the event that the insurance company does not pay as much as expected, I understand that the remaining balance is due and payable immediately by me, the patient. I understand that, as a third party, Ridge Commons Family Dentistry cannot become involved in prolonged insurance negotiations. I authorize the use of my signature on all insurance submissions.

Ridge Commons Family Dentistry may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____

Please print name of Patient or Parent/Legal Guardian — Relationship to Patient