DATE

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: $0.00 Rem. Deduct: $0.00

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: $0.00 Rem. Deduct: $0.00

Ridgepoint Dental

Eaglesoft Medical History

Patient Name:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
						Yellow Jaundice	Yes No

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

VELscope Oral Cancer Consent Form

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient. **One American dies every hour from oral cancer.** Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is a primary risk factor for oral surgery. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk: *Patients ages 19-39*

High risk: *patients age 40 and up; tobacco users (any age, any type within 10 years)*

Highest risk: *Patients age 40 and up with lifestyle risk factors (excessive tobacco & alcohol use) with previous history of oral cancer*

We have incorporated **VELscope** into our oral screening standard of care. We find that using the VELscope along with standard oral cancer examination improves the ability to identify suspicious areas at their earlier stages. **VELscope** is similar to proven early detection procedures for other cancers such as mammography and PSA. **VELscope** is a simple and painless exam that gives the best chance to find any oral abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer as well as save your life.

The VELscope exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam might not be covered by insurance. The fee for this exam is $35.

*Signature:*_____ *Date:*_____

Ridgepoint Dental

151 Ridge point Parkway, Ste 400, Keller, TX, 76248

Ridgepoint Dental

In order to provide you with the best treatment and keep the cost of the treatment reasonable, we ask that you review our financial policy. We require that you read and sign the following statement and initial next to each paragraph.

Financial Policy

____Your portion for services rendered, deductible (if applied) and estimated co-payment are due at the time of service. We are more than happy to assist you with the filing of your insurance, however, keep in mind that the co-pay amount is an **ESTIMATE**. You are responsible for any account balance that is not paid by your insurance. Our policy is that we require your insurance to pay on claims in 60 days. I authorize payment of dental benefits otherwise payable to me directly to Ridgepoint Dental. If your claim becomes outstanding by 60 days, you will be notified on your next statement and the full balance will be due. We will no longer bill secondary insurance claims. A pre-authorization for treatment prior to starting treatment may be sent at your request; however, this is NOT a guarantee of payment by your insurance company.

____We accept payment in the forms of cash, check, Visa, MasterCard, and Care Credit. **Please be sure of your financial commitment to our office prior to starting any dental treatment.**

If you need any payment arrangements, the following options are available.

- Extended payment options through Care Credit Or Chase (Requires credit check)
- The fee for returned checks is $35.00

Arrangements must be made prior to the start of treatment.

____We request that in need to cancel an appointment, you give us at least 48 hours' notice. If 48 hours is not given, a fee of $75.00 per hour of the time reserved may be considered and charged to your account.

____Our billing company manages the mailing of statements for accounts with balances over 60 days old. A finance charge of a periodic rate of 1.25% per month will be imposed on charges not paid in full with 60 days. If your payment is not received by the due date, you may be assessed with a late payment charge of $5.00 or 5% of the past due amount, whichever is greater. If an account reaches 165 days old or great, an automatic fee of 50% of the balance will be added on the account to cover any fees for collection activity and attorney/court costs that may accrue.

____In the event of a divorce/separation, the parent/guardian that escorts their child to the dental office will be financially responsible for the payment regardless of an agreement between the parents of the courts.

____Our office utilizes mercury-free fillings (white fillings). Please be aware that insurances will down grade the price of composite (white) fillings to the silver (mercury or amalgam) filling price. You will be responsible for the difference.

____Original x-rays/ photos are the property of Ridgepoint Dental. If copies are needed, there is 10 business day turn around on x-ray copies and a $25.00 fee.

I, _____, have read and understood and agree to the above policy. I understand that I am fully responsible for the fees of service rendered regardless of any insurance that I may have.

_____ ____/____/____

Parent/Responsible Party Signature Date

Photography Release

I hereby authorize Ridgepoint Dental, to publish photographs taken of me during my dental office visits, and my name and likeness, for use in the Ridgepoint Dental's print, online and video-based marketing materials, as well as other office publications.

I hereby release and hold harmless Ridgepoint Dental from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other dental office publications. I acknowledge and agree that publication of photographs confers no rights of ownership or royalties whatsoever.

I hereby release Ridgepoint Dental, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Printed Name: _____

Signature: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____