

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 FemaleMarital 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

Section 3

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: _____

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

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? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever been hospitalized or had a major operation? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever had a serious head or neck injury? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Are you taking any medications, pills, or drugs? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Do you take, or have you taken, Phen-Fen or Redux? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |
| Are you on a special diet? | <input type="radio"/> Yes <input type="radio"/> No | | |
| Do you use tobacco? | <input type="radio"/> Yes <input type="radio"/> No | | |
| Do you use controlled substances? | <input type="radio"/> Yes <input type="radio"/> No | If yes | _____ |

Women: Are you...

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

Are you allergic to any of the following?

| | | | |
|----------------------------------|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Acrylic |
| <input type="checkbox"/> Metal | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Local Anesthetics |
| Other? <input type="checkbox"/> | | If yes | _____ |

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

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



Apple Dentistry
— OF KELLER —

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

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: _____