PATIENT INFORMATION (CONFIDENTIAL)

DATE_____

Name_____ Nickname_____
(Last) (First) (Middle Initial)

Address _____
(Street) (Apt) (City) (State) (Zip Code)

Social Security_____ Birthdate_____

Wk # _____ Hm # _____ Mobile# _____

Email_____

Check Appropriate: __Minor __ Single __Married __Divorced __ Widowed __Domestic Partner

Employer or Name of School _____

Whom may we thank for referring you? _____

Emergency Contact _____phone _____relationship_____

RESPONSIBLE PARTY – (Responsible for paying account)

Name_____ Relationship to Patient_____

Address_____

Driver's License_____ Birthdate_____

Is this person currently a patient in our office? __ Yes __ No

DENTAL INSURANCE INFORMATION

Name_____ Relationship to Patient_____

Birthdate_____ SS# / ID# _____

Employer _____ wk # _____

Insurance Carrier _____ Phone _____ Grp # _____

Ins Address _____ City_____ State _____ Zip_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? __YES __ NO IF YES, COMPLETE THE FOLLOWING:

Name_____ Relationship to Patient_____

Birthdate_____ SS# / ID# _____

Employer _____ wk # _____

Insurance Carrier _____ Phone _____ Grp # _____

Ins Address _____ City_____ State _____ Zip_____

Patient/Guardian Signature_____ **Date** _____

REGISTRATION

HEALTH HISTORY

English

PATIENT NAME:_____ **DATE OF BIRTH:**_____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? Yes/No For what?_____
   Date of last medical exam: _____
   Date of last dental exam: _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures? Epilepsy?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Snoring/Sleep Apnea?
17.	Yes	No	Difficulty urinating, blood in urine?				

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease? Heart Attack? Heart Defects?	40.	Yes	No	Tumors, cancer?
30.	Yes	No	Heart murmurs?	41.	Yes	No	Arthritis, rheumatism?
31.	Yes	No	Rheumatic fever?	42.	Yes	No	Eye diseases?
32.	Yes	No	Stroke, hardening of arteries?	43.	Yes	No	Skin diseases?
33.	Yes	No	High blood pressure?	44.	Yes	No	Kidney, bladder disease?
34.	Yes	No	High cholesterol?	45.	Yes	No	Thyroid, adrenal disease?
35.	Yes	No	Diabetes Type 1 or 2?	46.	Yes	No	Anemia?
36.	Yes	No	Asthma, TB, emphysema, other lung diseases?	47.	Yes	No	HPV
37.	Yes	No	Hepatitis, other liver disease? A/B/C (Circle)	48.	Yes	No	Herpes Simplex Virus 1 (Cold Sores)
38.	Yes	No	Stomach problems, ulcers? Crohn's, IBS, Celiac?	49.	Yes	No	Herpes Simplex Virus 2 (Genital)
39.	Yes	No	Allergies to: drugs, foods, medications, latex?	50.	Yes	No	HIV/AIDS?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care? ADD/ADHD? Anxiety? Depression?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Artificial joint?
55.	Yes	No	Pacemaker?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain:_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ **Date**:_____

PATIENT NAME_____ **Date of Birth**_____

Reason for this visit_____

When was your last dental visit_____What was done then_____

How often did you visit the dentist before then_____

General Dentist _____ Prior (if less than 2 yrs)_____

Have you had a complete series of x-rays taken (when/where)_____

How often do you brush your teeth_____ How often do you floss_____

Type of toothbrush used_____

Is your drinking water fluoridated_____

	YES	NO		YES	NO
Do your gums bleed while brushing/flossing	☐	☐	Do you bite your lips or cheeks frequently	☐	☐
Are your teeth sensitive to hot or cold	☐	☐	Have you noticed any loosening of your teeth	☐	☐
Are your teeth sensitive to sweet or sour foods	☐	☐	Does food get caught between your teeth	☐	☐
Do you feel pain to any of your teeth	☐	☐	Have you ever had periodontal treatment	☐	☐
Do you have any sores or lumps in or near			Ever worn a bite plate or other appliance	☐	☐
Your mouth	☐	☐	Have you ever had any difficulty with extractions	☐	☐
Have you had any head, neck or jaw injuries	☐	☐	Have you had prolonged bleeding after extractions	☐	☐
Have you ever experienced any of the following problems in your jaw?					
Clicking	☐	☐			
Pain (joint, ear, side of face)	☐	☐	Do you wear Dentures or Partials	☐	☐
Difficulty in opening or closing	☐	☐	If yes, date of placement_____		
Difficulty in Chewing	☐	☐			
Do you have frequent headaches	☐	☐	Have you ever received oral hygiene instruction		
Do you clench or grind your teeth	☐	☐	regarding the care of your teeth and gums	☐	☐

If you could change anything about your smile, what would you change?_____
_____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUSTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

DOCTOR'S COMMENTS _____

_____

Doctor Signature _____ Date _____

DENTAL HEALTH HISTORY

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Intown Dental
Amy Rigby, DDS

Patient Name: _____ Date of Birth**:** _____

I authorize the above listed doctor and practice to release my health care information to:

Name: _____

Name: _____

Name: _____

This request and authorization applies to ALL health care information including insurance and financial information unless otherwise specified:

_____

I understand that this authorization is voluntary. I understand that if the person (s) authorized to receive the information are not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Please read the following statements:

1.	I understand that this authorization will expire only upon termination of active patient status.
2.	I understand that I may revoke this authorization at any time by notifying the providing practice in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3.	I understand that my healthcare and the payment for my health care will not be affected if I do not sign this form.
4.	I understand that I may see and copy the information described on this form and may reqeust a copy of this form after it is signed.
5.	If I have questions about disclosure of my health information, I can contact the office staff or the doctor.

_____ _____

Signature of Patient or Legal Representative Date

_____

If Signed by Legal Representative, Relationship to Patient

This document will be retained by the providing organization for six years.

AMY RIGBY, DDS

Financial Agreement

Payment: Payment is expected in full for each appointment as services are rendered. Payment options are Cash, Check, Credit card (MasterCard, Visa, American Express, Discover), and Care Credit (Special financing on approved credit offering no interest plans).

Dental Insurance: As a service to our patients, our practice accepts most dental insurance programs as a PPO in-network provider. However, we remind you that your specific policy is an agreement between you and your insurance company**. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated.** The fees charged for services rendered to those who are insured are the usual and customary fees charged to all our patients for similar services. Your policy may base its allowances on a fixed fee schedule, which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the types of coverage available. Also, some companies take care of claims promptly while others delay payment for several months.

Missed Appointment Fee: Your appointment is important to us. When you schedule the appointment, we reserve the Doctor's, assistant's, and/or hygienist's time and make preparations for your arrival. We do not wish to charge missed appointment fees, however, after multiple missed appointments, we may charge a **cancellation fee of $50 if you cancel, reschedule, or miss your appointment without giving 24 hours notice.** Patients with three missed appointments may be asked to transfer their records to another doctor.

Returned Checks: There is a fee ($25.00) for any checks returned by the bank.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

This is an agreement between us and the Patient/Debtor named on this form.
In this agreement the words "you" and "yours" means the account that has been established in your name to which charges were made and payments are credited. The words "we," "us", and "our" refer to Intown Dental, PC.
By executing this agreement, you are agreeing to pay for all services that are received.

Name: _____

Patient/Responsible Party Signature: _____
Date:_____