Ramos Boyd DENTISTRY

Patient Registration and Health History
Please complete the following confidential information

Patient Information

Name: _____ Date: _____

Spouse: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Birthday: _____ Age: _____ Male Female Marital Status: _____

Social Security: _____ Email: _____

Parent or Guardian Information

Name: _____

Address (if different from above): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Getting to know you

Who can we thank for referring you? _____

Which other member of your family or relative is a patient at our office? _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone Number: _____

Closest relative not living with you: _____ Phone Number: _____

Person financially responsible for account: _____

Home Phone: _____ Cell Phone: _____

Dental Insurance

Primary Insurance

Insurance Company: _____ Employer: _____

Group Number: _____ Employee: _____

Employee's Date of Birth: _____ Employee's Social Security: _____

Secondary Insurance

Insurance Company: _____ Employer: _____

Group Number: _____ Employee: _____

Employee's Date of Birth: _____ Employee's Social Security: _____

Dental History

Name: _____ Previous Dentist: _____
Date of last exam: _____ Date of last x-rays: _____
Reason for appointment: _____

Check all that apply

- ☐ Current dental problems
- ☐ Teeth sensitive to hot or cold
- ☐ Pain with chewing
- ☐ Loose teeth
- ☐ Food gets caught between teeth
- ☐ Pain or swelling in gums
- ☐ Bleeding gums
- ☐ Growths or sore spots
- ☐ Snoring
- ☐ Bad breath
- ☐ Previous orthodontic treatment
- ☐ Previous periodontal treatment
- ☐ Had teeth ground or adjusted
- ☐ Worn a nightguard or splint
- ☐ Nervous about dental treatment
- ☐ Pain or ringing in ears
- ☐ Tired feeling in face
- ☐ Clench or grind teeth
- ☐ Frequent headaches
- ☐ Pain around ears, eyes, head, or neck

What, if anything, would you change about the appearance of your teeth? _____
What concerns you most about your mouth? _____
Is there anything else about dental treatment that bothers or concerns you? _____

Health History

Physician's Name: _____ Telephone Number: _____
Have you been a patient in the hospital within the past two years? ...…….....yes no
Have you been under the care of medical doctor during the past two years? …….……..yes no
Are you taking any medication, drugs, or pills at this time? ……yes no
If yes, please list: _____
Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? … yes no
If yes, please list: _____

Indicate which of the following you have had or have at present. Circle Yes or No.

Heart Failure……...	yes	no	Stroke……..	yes	no	Radiation Therapy……..	yes	no
Heart Disease or Attack…..	yes	no	Artificial Joints……...	yes	no	Chemotherapy…….	yes	no
Angina Pectoris……..	yes	no	If yes, list: _____			Hepatitis…Type_____.....	yes	no
Congenital Heart Disease...	yes	no	Kidney Trouble……...	yes	no	Venereal Disease……	yes	no
Heart Murmur…….	yes	no	Ulcers……..	yes	no	A.I.D.S……	yes	no
High Blood Pressure……...	yes	no	Diabetes……..	yes	no	H.I.V. Positive……	yes	no
Arteriosclerosis……...	yes	no	Thyroid Problems……...	yes	no	Cold Sores/Fever Blisters...	yes	no
Mitral Valve Prolapse…….	yes	no	Glaucoma……	yes	no	Blood Transfusion……..	yes	no
Artificial Heart Valve…….	yes	no	Cosmetic Surgery……...	yes	no	Hemophilia…….	yes	no
Heart Pacemaker…….	yes	no	Emphysema……	yes	no	Anemia……	yes	no
Heart Surgery……..	yes	no	Chronic Cough……	yes	no	Sickle Cell Disease…….	yes	no
Rheumatic Fever…….	yes	no	Tuberculosis……	yes	no	Liver Disease……..	yes	no
Arthritis……...	yes	no	Asthma……	yes	no	Jaundice……..	yes	no
Rheumatism……	yes	no	Hay Fever……...	yes	no	Epilepsy or Seizures……...	yes	no
Pain in Jaw Joints……...	yes	no	Allergies…….	yes	no	Fainting or Dizzy Spells….	yes	no
Cortisone Medication…….	yes	no	Sinus Trouble…….	yes	no	Nervousness……	yes	no
Drug Addiction……...	yes	no	Cancer or Tumor…….	yes	no	Psychiatric Treatment…….	yes	no

Do you have or have you had any disease, condition, or problem not listed? yes no
If yes, please list: _____

Have you had any surgeries? yes no
If yes, please list: _____

Women Only: Are you pregnant? yes no If yes, what month? _____
Are you nursing? yes no Are you taking birth control pills? yes no

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature: _____ Date: _____ Staff Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____ _____
Please print your name here *Signature* *Date*

I, _____, authorize Ramos Boyd Dentistry to disclose my health information with the following people: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)* _____

_____ _____
Employee signature *Date*

Email Release Form

Ramos Boyd Dentistry staff can communicate via e-mail on matters related to your health and/or your dental treatment. We also invite you to participate in our online reminder system through Demandforce. Features include:

* Receive Text Message Appointment Reminders
* Confirm Appointments via Email
* Request Appointment Online
* Submit Patient Satisfaction Surveys
* Refer Your Friends Online

I want to receive text messages. ___Yes ___No I want to receive e-mails. ___Yes ___No

Cell Phone Number: _____ Email Address: _____

If you opt yes, you are allowing Demandforce to use this information in providing your services.

- I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members, liable for loss of any confidentiality associated with information transmitted via e-mail.
- I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent to me via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.
- Demandforce may disclose Patient Health Information (PHI) to third parties that perform services for Burkholder and Ramos Family DDS in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. **OUR AFFILIATES DO NOT SELL, SHARE OR RENT OUR USERS' PERSONALLY IDENTIFIABLE INFORMATION UNLESS REQUIRED BY LAW, DO NOT SEND ANY EMAIL OR OTHER COMMUNICATIONS WITHOUT USER PERMISSION, AND DO NOT SEND SPAM.**

Signature _____ Date _____

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DENTAL INSURANCE POLICY

We are pleased you have selected our office for your dental care. Our mission is to provide the highest level of quality dentistry in a relaxed, compassionate manner.

Your dental benefit program is a wonderful asset to assist you in obtaining and maintaining a superior level of oral health. It is a contract between you, your employer, and the insurance company. We are not a party to that contract. Your employer chooses the plan for you. Some plans have good coverage and reimburse well, while others do not. Sometimes dental services we perform for you are not covered by your plan, and some plans only cover a portion of the fee. Payment for those differences is your responsibility.

Your first visit will need to be paid for by you. Fees for subsequent visits will be submitted to your insurance company, and you will only need to pay the estimated difference (co-pay and deductible) at the time of service. Payment for any service rendered to you, of course, ultimately remains your responsibility.

We will be happy to process your insurance for you. We will also take assignment of the payments after your first visit if that is your preference. Should your insurance company fail to pay after sixty days from your receiving treatment, then you will need to pay your bill and seek reimbursement from your insurance company. It has been our experience that insurance companies reimburse the policy holders much more quickly than the dental provider.

Any procedure greater than $200.00 will require a predetermination of benefits from the insurance company. If you would like to begin your work immediately, then you may pay the fee in full at the time of service, and be reimbursed by your insurance company.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

_____

Patient/Guardian Signature Date

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the above named dentist or dental entity.

_____

Patient/Guardian Signature Date

Witness: Staff Signature: _____

Date