Ramos Boyd DENTISTRY

Patient Registration and Health History
Please complete the following confidential information

Patient Information

Name: _____ Date: _____
Spouse: _____ DL#: _____
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: _____ Relationship: _____
Emergency Contact Phone Number _____
Person financially responsible for account: _____
Home Phone: _____ Cell Phone: _____

Dental Insurance

Primary Insurance
Insurance Company: _____
Group Number: _____
Employer: _____
Employee: _____
Employee's Date of Birth: _____
Employee's Social Security: _____

Secondary Insurance
Insurance Company: _____
Group Number: _____
Employer: _____
Employee: _____
Employee's Date of Birth: _____
Employee's Social Security: _____

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/Text Release Form

Ramos Boyd Dentistry staff can communicate via e-mail and text message 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

Would you like to receive Billing Statements through Text Message? ___Yes ___No

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 Ramos Boyd Dentistry 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 _____

Dental History

Name: _____ Previous Dentist: _____

Date of last dental exam: _____ Date of last dental x-rays: _____

Reason for today's appointment: _____
Are you currently experiencing any dental pain or discomfort? yes no
If yes, where? _____

Please use an "X" to mark your answers to the following questions.	**Yes**	**No**
Do your gums bleed when you brush or floss your teeth?		
Have you ever had periodontal (gum) treatments like scaling and root planing?		
Do you have, or have you ever had, any sores or growths in your mouth?		
Do you clench or grind your teeth?		
Does your jaw click, pop or hurt?		
Do you have earaches or neck pains?		
Do you wear or have you worn a nightguard?		
Do you snore or have trouble breathing during sleep?		
Have you had previous orthodontic treatment (braces)?		
Does dental treatment make you nervous?		
Have you ever had a reaction to, or problem with, dental anesthesia?		

If yes, please describe what happened: _____

Have you ever had problems with dental treatment in the past?		

If yes, please describe what happened: _____

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: _____ Preferred Pharmacy: _____

Has a physician or dentist recommended that you take antibiotics before having dental work done? ……..yes no

Are you taking any blood thinners? (such as Coumadin, Warfarin, Xarelto, Plavix, heparin, or aspirin) .....yes no

Are you taking any medication to treat osteoporosis or Paget's disease? (such as alendronate (Fosamax), Actonel, Boniva, Reclast, or Prolia) ……..….yes no

Please list all prescription medications, over the counter medications, or supplements that you are currently taking? _____

Are you aware of being allergic to or have you ever reacted adversely to any medication or substance? … yes no
If yes, please list: _____

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

Have you had any type (either total or partial) of joint replacement surgery (such as a hip, knee, etc.)? …..yes no
If yes, please explain: _____

Have you had a heart valve replacement or heart surgery? ...…….…….....yes no

If yes, please explain: _____

Do you have or have you been diagnosed with any type of cancer?.....yes no

If yes, list type and date of diagnosis: _____

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

Heart Failure or Disease.....	yes	no	Emphysema……	yes	no	Blood Transfusion……..	yes	no
Heart Attack……...	yes	no	Chronic Cough……...	yes	no	Hemophilia…….	yes	no
Angina Pectoris……..	yes	no	Tuberculosis……...	yes	no	Anemia……	yes	no
Congenital Heart Disease...	yes	no	Asthma…last attack_____.	yes	no	Sickle Cell Disease…….	yes	no
Heart Murmur…….	yes	no	Sinus Trouble…….	yes	no	Epilepsy or Seizures……	yes	no
High Blood Pressure……..	yes	no	Seasonal Allergies……..	yes	no	Fainting or Dizzy Spells..	yes	no
Arteriosclerosis……..	yes	no	Kidney Trouble……..	yes	no	Nervousness……	yes	no
Mitral Valve Prolapse……	yes	no	Ulcers…….	yes	no	Psychiatric Treatment….	yes	no
Heart Pacemaker……	yes	no	Thyroid Problems……...	yes	no	Arthritis……..	yes	no
Infective endocarditis…….	yes	no	Hepatitis…Type_____.....	yes	no	Rheumatism……	yes	no
Rheumatic Heart Disease...	yes	no	Jaundice…….	yes	no	Pain in Jaw Joints……	yes	no
Stroke…….	yes	no	Liver Disease…….	yes	no	Cortisone Medication…..	yes	no
Diabetes…Type_____……	yes	no	Sexually Transmitted Disease.	yes	no	Cosmetic Surgery……	yes	no
Glaucoma……...	yes	no	AIDS or HIV Positive……	yes	no	Drug Addiction……...	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 not listed? 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: _____

Appointment and Financial Policy

Appointments

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. We view our patients' care with a deep sense of responsibility, and because of this we reserve an appointment time that is solely dedicated for your treatment.

- As a courtesy, we send reminders of your appointment via phone, email, and/or text. Please confirm your appointment when you receive a reminder. Appointments that are unconfirmed 24 business hours prior to the appointment may be rescheduled by our office.
- If you are more than 15 minutes late for your appointment, we may need to reschedule.
- If you need to cancel or reschedule, we require at least 1 business days' notice prior to your appointment. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge will be assessed for multiple missed, short notice or cancelled appointments.
- Minors cannot be seen if not accompanied by a guardian at the time of their appointment. This guardian must be able to make payment as well as decisions in case of an emergency.

Financial

Payment is due at the time service is provided. This includes deductibles, copays, and any pending balance. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and CareCredit. We do not accept postdated checks.

- All returned checks will be subject to a $35 returned check fee. This fee covers the bank service charge.
- Any account balances that remain unpaid for 90 days from the date of service shall accrue interest of 18% per year and may be referred to a collection company or attorney.
- The card holder must be present and have their driver's license when paying with CareCredit.
- When scheduling an appointment requiring 2 or more hours, a deposit is required to confirm and hold the appointment. This deposit will be applied to the total cost of the scheduled treatment. The deposit must be made when scheduling the appointment. Please note, you will forfeit your deposit should you fail to follow the Appointment and Financial Policy.

Insurance

Any insurance you provide is an agreement between you and your insurance provider. We are not a party to this agreement. Any estimate of what your insurance may cover, even when an estimate of benefits was obtained, is not a guarantee of coverage. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

- I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 60 days after being billed by the dentist.

- We are In-Network with most Ameritas, Principal, Aetna, Guardian, Humana, and Cigna insurance plans. We will verify benefits for you as a courtesy, but it is ultimately your responsibility to verify that our office is in-network with your insurance plan.

- We are Out-of-Network with all other plans. Patients with out-of-network plans are required to pay the full fee for services at the time they are provided. As a courtesy, we will file claims for out of network plans for payment to go directly to the subscriber. Please let us know if you have not received a reimbursement from your insurance and we will follow up on the claim.

- It is your responsibility to inform us of any change in your insurance coverage before the start of your appointment. We cannot guarantee same day insurance verification. If that is the case, full payment will be due at the time of your visit. Once insurance payment has been received you will be reimbursed any monies due.

- I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. For insurance companies that accept an assignment of benefits, I assign to the dentist all the insurance benefits due to me for services, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company to make payment directly to the dentist. For insurance companies that do not accept the assignment, I understand that I am responsible for the full charges and my insurance will issue payment directly to the subscriber of the insurance.

I have read, understand, and agree to the above Appointment and Financial Agreement.

_____

Patient/Guardian Name

_____

Patient/Guardian Signature Date

Witness: Staff Signature: _____

Date