RIVER ROCK DENTAL

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT – ALL SECTIONS ARE REQUIRED)

Date_____

Patient_____
First Name Middle Initial Last Name Preferred Name

Street Address_____ City_____ State_____ Zip_____

E-mail_____ Patient Social Security #_____-_____-_____

Sex ☐M ☐F Age_____ Birthdate_____ Home Phone (_____)_____

☐ Married ☐ Widowed ☐ Minor Cell Phone (_____)_____Carrier:_____

☐ Single ☐ Separated ☐ Divorced

If patient is a child, what is his/her weight?_____

Employer/School_____ Occupation_____

Address_____ Work Phone (_____)_____Ext:_____

Spouse / Parent

Spouse/Parent Name_____ Spouse/Parent Birthdate_____

Spouse/Parent Employed by_____ Spouse/Parent Social Security #_____-_____-_____

Responsible Party

Who is responsible for this account?_____ Relationship to Patient_____ SS#_____-_____-_____

Name of Dental Insurance Company_____ Group Number_____

In case of emergency, who should be notified?_____ Phone (_____)_____

How did you hear about our office? ☐Flyer ☐Radio/TV ☐Phone Book ☐Internet ☐Friend (Name:_____) ☐Other_____

MEDICAL HISTORY

Has the patient ever had any of the following? (check all boxes that apply):

☐ Allergies	☐ Epilepsy	☐ Ulcer
☐ Arthritis	☐ Headaches	☐ Psychiatric Care
☐ Artificial Heart Valves or Joints, Screws, etc.	☐ Heart Murmur/Problems	☐ Radiation Treatment
☐ Back Problems	☐ Hemophilia	☐ Recent Weight Loss
☐ Bleeding Abnormally/Blood Disease	☐ Hepatitis or liver disease	☐ Respiratory Disease
☐ Nervous Problems	☐ Jaundice	☐ Rheumatic Fever
☐ Cancer	☐ Pacemaker	☐ Sinus Problems
☐ Chemical Dependency	☐ High Blood Pressure	☐ Special diet
☐ Circulatory Problems	☐ Low Blood Pressure	☐ Stroke
☐ Congenital Heart Lesions	☐ HIV/AIDS	☐ Swollen Neck Glands
☐ Diabetes	☐ Mitral Valve Prolapse	☐ Venereal Disease

Physician's Name_____ Date of Last Physical_____

Are you under the care of a physician? ☐ Yes ☐ No For what condition(s)?_____

Are you taking any medication at this time? _____ If so, what?_____

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ☐ Yes ☐ No

If so, what?_____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No If yes, what is your due date _____

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of

_____.

Please Print Name of Minor/Child

I am not legally prohibited from signing this consent. By signing below, I request and authorize the River Rock Dental staff to perform necessary dental services for the above named child, including but not limited to x-rays, emergency treatment, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. This consent will remain in effect until revoked in writing.

_____ _____

Signature of Patient or Guardian Date

BENEFITS ASSIGNMENT AND RELEASE

I understand that, as a courtesy, River Rock Dental will assist me in filing claims for my dental treatment with my benefit company. I understand that it is the responsibility of the patient/guardian to know the coverages and restrictions of the benefit company and that the contract is between the patient and the benefit company. I agree that River Rock Dental is not responsible for procedures that may not be covered by the benefit company.

I certify that I and/or my dependent(s) have dental benefits through

_____.

Name of Dental Benefit Company(ies)

I assign directly to THE DOCTORS OF RIVER ROCK DENTAL, P.C. all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges <u>whether or not</u> paid by the benefit company. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my or my minor/child's health care information and may disclose such information to the benefit company(ies) named above and their agents for the purpose of obtaining payment for rendered services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient or Guardian Date

FINANCIAL AGREEMENT

I acknowledge that all payment are due <u>at the time of treatment</u>, unless other arrangements are made in advance. I agree that parents, guardians or personal representatives are responsible for all fees for treatment of a minor/child. I accept full financial responsibility of all charges for services or items provided to me or the patient. I understand that filing a claim with my dental benefit company <u>does not</u> relieve me from my responsibility for the payment of all charges. Unpaid balances will be assessed a monthly charge (5% up to 12%; minimum charge of $5.00.) I understand and agree to pay any and all charges.

_____ _____

Signature of Patient or Guardian Date

CERTIFICATION

The information provided on this form is complete and correct to the best of my knowledge. I understand that it is my responsibility to inform my doctor prior to my treatment or treatment **o**f my minor child if there has been any change in health condition.

_____ _____

Signature of Patient or Guardian Date

OFFICE POLICIES

I. CONFIRMATION

1. As a courtesy, River Rock Dental will contact the patient prior to the appointment through our automated text service to remind him or her about the scheduled time, and answer any questions he or she may have. If the patient prefers to be contacted through another method, please let our office staff know.

2. If the patient is not contacted, he or she will still be expected to come to their appointment on time.

II. INSURANCE

River Rock Dental will assist with insurance submission as a courtesy. However, we expect the patient or guardian to know the coverage and the limitations on the policy. It is the patient's or guardian's responsibility to make sure that all balances are paid in full.

III. BROKEN APPOINTMENTS

1. A broken appointment is defined as:
    a. A patient not showing for an appointment, or showing too late for scheduled treatment.
    b. An appointment cancelled with less than a 24 hour notice.

2. Broken appointments may make the patient ineligible to be seen in this office again. If necessary, we will send the records to the doctor of the patient's or guardian's choice.

IV. RESPECT

We expect our office to treat all persons with respect. Our office expects the same in return from all persons. Therefore, if any person uses offensive language, inappropriate volume, or other non-professional treatment of the office staff, he or she may be asked to no longer receive treatment at our office. The records can be sent to an office of the patient or guardian's choice.

V. COLLECTIONS

If, for any reason, we must resort to collecting money owed to River Rock Dental either through a collection agency or some other means, the patient or guardian will be responsible to pay all collection fees and/or interest charged for past due accounts. Unpaid balances sent to a collections agency will be assessed a 12% collection fee.

VI. HIPPA

River Rock Dental complies with all government privacy regulations. At the patient or guardian's request, he or she has been given the opportunity to review the HIPPA Privacy Policy Act.

I have read, accept, and will comply with all of the above information provided by River Rock Dental.

_____ _____

Signature of Patient or Guardian Date