# PATIENT INFORMATION

Welcome to our practice! So that we may provide you with the best possible care, please complete both sides of this questionnaire. All information is completely confidential.

PATIENT NAME _____TODAY'S DATE_____

DATE OF BIRTH _____SEX_____SS#_____

ADDRESS _____CITY_____STATE_____ZIP_____

EMAIL ADDRESS _____

HOME PHONE_____WORK PHONE _____ CELL _____

PREFERRED METHOD OF CONTACT_____

MARITAL STATUS _____ SPOUSE'S NAME_____

EMPLOYER_____ HOW LONG?_____

EMPLOYER ADDRESS _____CITY_____STATE_____ZIP_____

ARE YOU A STUDENT? _____ SCHOOL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

IF YOU ARE A MINOR, PERSON RESPONSIBLE FOR YOUR ACCOUNT_____

RELATIONSHIP TO PATIENT_____

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?_____

RELATIONSHIP TO PATIENT _____ PHONE #_____

# DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME _____ SS#_____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT _____ EMPLOYER _____

EMPLOYER ADDRESS _____ CITY_____ STATE_____ ZIP _____

SUBSCRIBER #_____ GRP # _____

INSURANCE COMPANY _____

CLAIM FILING ADDRESS _____CITY_____ STATE_____ ZIP_____

INSURANCE PHONE #_____

OVER ----------→

# MEDICAL HISTORY

Have you been under the care of a physician during the past two years?_____

If so, for what?_____

Physicians Name_____ Phone _____

What medications are you currently taking? _____

Do you smoke? _____ If so, how much per day? _____

Do you drink alcohol? _____ If so, how much per day? _____ per week? _____

Are you allergic to any medications, if yes please list _____

Are you allergic to any other substance, if yes please list _____

Are you currently pregnant? _____ If yes, what is your due date? _____

Have you been hospitalized in the past five years?_____

Have you ever been advised by a Physician to pre-medicate with antibiotics prior to dental treatment? _____

If so, please explain _____

Please check if you have a history of the following:

| | | | |
|---|---|---|---|
| _____ HEART ATTACK | _____ HEART SURGERY | _____ HEART DISEASE | _____ CHEST PAIN |
| _____ RHEUMATIC FEVER | _____ HEART MURMER | _____ HIGH BLOOD PRESSURE | _____ PACEMAKER |
| _____ ARTIFICIAL VALVE | _____ ARTIFICIAL JOINT | _____ ARTHRITIS | _____ STROKE |
| _____ TUBERCULOSIS | _____ GLAUCOMA | _____ ULCER | _____ DEPRESSION |
| _____ EMPHYSEMA | _____ DIABETES | _____ THYROID PROBLEMS | _____ ASTHMA |
| _____ RADIATION/CHEMO | _____ CANCEROUS TUMORS | _____ HEPATITIS | _____ AIDS/HIV |
| _____ EPILEPSY | _____ SEIZURES | _____ FAINTING/DIZZINESS | _____ HAY FEVER |
| _____ MITRAL VALVE PROLAPSE | _____ BLOOD DISORDER | _____ SHORTNESS OF BREATH | _____ ADD/ADHD |
| _____ VENEREAL DISEASE | _____ LATEX SENSITIVITY | _____ CONTACT LENSES | |

# DENTAL HISTORY

What is the reason for your visit today?_____

Date of last dental visit _____ Previous Dentist _____

If you have a history of any of the following, please put a check next to it:

| | | | |
|---|---|---|---|
| _____ TOOTH SENSITIVITY | _____ GUMS BLEED/HURT | _____ FOOD IMPACTION | _____ MOUTH ODORS |
| _____ UNPLEASANT TASTE | _____ PAIN AROUND EAR | _____ CLENCHING/GRINDING | _____ ORAL HABIT |
| _____ SMOKING | _____ SWELLING/ LUMPS | _____ PERIODONTAL | _____ DRY MOUTH |

_____ COMPLICATIONS AFTER DENTAL VISIT

Patient Signature _____ Date_____

# FINANCIAL POLICY

We are a fee for service practice. Although we treat patients with many types of insurance coverage, we are not contracted with any insurance companies. As a convenience to our patients we will file a claim with your insurance company. Insurance coverage is a contract between the patient and his/her insurance carrier. We cannot guarantee if, how, or when your insurance company pays. Patients who carry dental insurance understand that all dental services furnished are charged in full directly to the patient. We offer 3 payment options:

_____ 1) Patients without insurance: Payment in full is due at time of treatment.

Patients with Insurance:

_____2) Payment is made in full at time of treatment. As a courtesy, we will file with your insurance carrier and have payment sent directly to you.

_____3) We will estimate what your out-of-pocket expense will be and this amount is due at time of treatment. As a courtesy, we will file with your insurance carrier. We will allow up to 45 days for your insurance to remit payment. When we receive payment from your insurance company, any balance left unpaid will be charged to your credit card. Should we not receive payment from your insurance carrier within 45 days, any unpaid balance will be charged to your credit card. This will require that you leave your credit card information on file with the office.

By signing below, you allow us to release information to your insurance company for the purpose of claim filing and you allow your insurance company to release assignment of benefits to us if applicable.

Any fee estimate given for dental care can only be extended for a period of three months from the date of the estimate.

**We do require that our patients provide us with at least a 48-hour notice to cancel an appointment in order to avoid a cancellation fee of 50% of the fees for the work scheduled for that appointment. _____ (initial). At our discretion if you have failed your appointment time more than once you may be required to pre pay for your service.**

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

** By signing this form, you acknowledge and understand that all payments are due at the time *services are rendered*. Also be advised that we do use a collection company for any defaulted balances. Accounts that are sent to collections will then be responsible for the defaulted balance, plus a 50% collection fee. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**Payment Options:**

1. Cash---includes money orders and personal checks.
2. Visa/Mastercard---includes debit cards with the Visa/Mastercard logo.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of guarantor of payment/responsible party

# Elizabeth Riggs Dentistry

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

Please sign below if you authorize Dr. Riggs to speak with other providers, and/or share any dental records, if needed, regarding your dental treatment.

_____

Signature Date

_____

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

_____

_____

_____