Patient Information

Patient Name: ____ Date:_______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_______________

Birth Date: _______________Age: ___________ Social Security #: ________________________________

Address: ____
Mailing/Physical City State Zip Code

Email: ____

Phones: Home ____________________ Work _____________________ Cell_______________________

Patient Health Information

Date of Last Dental Visit: _________________ Reason for this visit:_________________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS
☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valves
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Transfusion
☐ Cancer
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Mitral Valve Prolapse
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
OTHER:
☐ _________________
☐ _________________

• Are you allergic to or have you reacted adversely to any of the following? Please check those that apply:

☐ Aspirin ☐ Local Anesthetic ☐ Erythromycin ☐ Latex
☐ Nitrous Oxide ☐ Codeine ☐ Penicillin

• Are you aware of being allergic to any other foods, medications or substances? ☐ Yes ☐ No
If yes, please explain:____

• Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain:____

• Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain:____

• Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain:____

• Name of Physician: ____ Phone:___________________

• Are you taking any medications? ☐ Yes ☐ No
If yes, please list:____

• Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain:____

Have you ever had any of the following? Please check those that apply:

☐ Bleeding Gums
☐ Tender, Irritated Gums
☐ Periodontal (Gum) Treatment
☐ Dentures
☐ Unhappy with Dentures
☐ Apprehension
☐ Hot, Cold Sensitivity
☐ Sensitivity to Sweets or Pressure
☐ Grinding, Clenching
☐ Braces on Teeth
☐ Discolored Teeth
☐ Headaches, earaches or neck pain

To the best of my knowledge, all of the above answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:___________________
Signature of Patient, Parent or Guardian

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

Social Security #: ____________________ Birth Date: ____________ Driver's License #: ______________

Phones: Home ____________________ Work __________________ Relation to Patient: ______________

Address: ____
Mailing Physical

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ___________________________ Occupation: ______________ # of Years Employed: _____

Emergency Information: Relative Not Living With You

Name: ___________________________ Relationship: _____________________ Phone: _____________

Address: ____

Street ______________________________ City ____________ State _______ ZipCode __________

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _______________ I.D #: ____________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _______________ Soc Sec #: ____________________ Group #: ________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other__________________

Insurance Plan Name and Address: ____

Referral Information (Please Complete)

Whom may we thank for referring you to our practice? ☐ Another patient, friend* ☐ Another patient, relative*

☐ Dental Office ☐ Newspaper ☐ Work ☐ Postcard ☐ Letter ☐ Other__________________

*Name of person or office referring you to our practice: ______________________________________
PLEASE SPECIFY NAME OF REFERRING PARTY. THANK YOU!

CONSENT FOR SERVICES

Our office strives to provide the highest quality dental care. We believe our patients, honored guests, should receive prompt attention and excellent service. We believe a satisfied patient returns for additional services and refers others they feel would benefit from our

services to the practice. To help maintain a good relationship with our patients, this office has adopted the following financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office. Our office communicates this policy to each patient.

For those with insurance benefits, we bill your insurance as a courtesy, and at no additional cost. Your insurance contract exists solely between you and your insurance carrier. We will file your insurance claim, but we cannot guarantee any benefits. Your insurance plan is a benefit to help offset the cost of necessary dental care. Ultimately, you are responsible for the entire cost of your dental treatment. By signing, you authorize release of any information to third party payers and other health practitioners. You also assign all insurance benefits to Dr. Andy Koultourides, DDS / Ridge Dental Care.

By signing, you authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of your dental needs. Further, you also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. By signing, you also indicate your understanding that the use of anesthetic agents embodies a certain risk. Additionally, your intraoral pictures and radiographs may be used for patient education or marketing.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed, including the estimated portion of any amount, which your insurance does not cover. We accept the following payment options for pre-arranged treatment: Cash, Check, Discover, American Express, MasterCard and VISA.

When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 30 days, an interest rate of 1.5% per month will be assessed on all outstanding balances, or a minimum of $5 per statement period. By signing, you also understand a credit report will be generated on each new patient that is offered payment arrangements. A credit report may also be generated on established patients, prior to extending payment arrangements. Payment history with our office may be taken into consideration when establishing payment arrangements.

You also understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of your or the patient's examination.

A statement for services rendered will be mailed to you at the end of each month. Receipt of payment is expected by the 10th of the month. If payment is not received by the 10th, a late charge of $20.00 will be assessed and will appear on the next statement.

A $35.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still unavailable, we reserve the right to not accept payments by check from you in the future. Delinquent accounts may be sent to a collection agency or an attorney at the option of the dental practice. In the event of default, (we) promise to pay legal interest on the indebtedness, together with such collection cost and reasonably attorney fees as may be required to effectively collect account balance.

There will be no charge for an appointment that is cancelled with at least 48 hours notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. Broken appointments with less than 48 hours notice will incur a $50.00 fee. This fee covers arrangements the dental practice has made to reserve your treatment time, have your room fully prepared, and staff standing by to serve you.

By signing, I hereby grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form and payments. In addition, unless I notify you otherwise, you may use my written comments in material to educate or promote Ridge Dental Care / Dr. Andy Koultourides.

I have read the above conditions and agree to their content.

__________________________________ Date: _____________ Relationship to Patient: __________________

Signature of patient, parent or guardian