RIDGEPLEX DENTAL CARE

Date:

SS#:

PATIENT REGISTRATION

PATIENT INFORMATION

Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

BELOW PLEASE PLACE A CHECK IN THE BOX OF YOUR PREFERRED METHOD OF CONTACT

☐ Home Phone _____ ☐ Cell Phone _____ ☐ Email _____

Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Marital Status Single Spouse or Parent/Guardian's Name _____

Employer _____ Work Phone _____ Referred by? _____

RESPONSIBLE PARTY

Person Responsible for Account _____ Relationship _____

Address (if different) _____ Phone _____

SS# _____ DL# _____ Birthdate _____

Employer Name and Address _____

Work Phone _____ Financial Institution _____ Is this person currently a patient in our office? ☐ Yes ☐ No

Please select the payment method you prefer. Payment in full at each appointment. Cash

INSURANCE INFORMATION

Name of Insured _____ Relationship _____ Birthdate _____

SS# _____ Employer Name and Address _____

Date Employed _____ Work Phone _____ Union or Local # _____

Insurance Co. _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No **If yes, complete the following:**

Name of Insured _____ Relationship _____ Birthdate _____

SS# _____ Employer Name and Address _____

Date Employed _____ Work Phone _____ Union or Local # _____

Insurance Co. _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

WILLIAM J. SCHOEPFEL, DDS

1730 E. RIDGE RD., ROCHESTER, NY 14622
PHONE: 585.544.7139 | FAX: 585.338.7459

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain	☐	☐
Are you taking any medication(s) including non-prescription medicine? If yes, please explain	☐	☐
Have you ever taken *Fen-Phen/Redux*?	☐	☐
Have you ever taken *Fosamax, Boniva, Actonel* or any cancer medications containting *bisphosphonates*?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐

Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)		
Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
Pre-Menopausal Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Heart Trouble	☐	☐
Kidney Disease	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other	☐	☐

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw injuries?	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement		
Have you ever recieved oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
Do you like your smile?	☐	☐

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient (or parent/guardian) _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Relationship to Patient _____

PLEASE PRINT

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: Initials:

Reason:

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OFFICE FINANCIAL POLICY

Our financial policy has been set up to prevent misunderstandings. We are committed to your treatment being successful. Thank you for choosing us as your healthcare provider.

1) Full payment is expected at the time of service.

2) We accept cash, check, visa/mastercard, discover and care credit.

3) Unless canceled at least 48 hours in advance, our policy is to charge for missed appointments at the normal rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

4) Returned checks are subject to a $25.00 service charge and will terminate your privilege to pay on future visits with a check.

5) Regarding insurance plans, the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and original claim form. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. Please be aware that some, and perhaps all of the services provided may be non-covered and not considered reasonable or necessary under the dental insurance.

6) For any outstanding balance past 30 days a billing charge may be added.

7) It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney's fees.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. Please sign below.

Signature _____ Date _____

WILLIAM J. SCHOEPFEL, DDS

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