PRESTON RIDGE DENTAL
Family & Cosmetic Dentistry

Registration and Health History- Internet Form

Today's Date: _____ Reason for this visit: _____

Patient's Name: _____ DOB: _____ SS#: _____

Address: _____ City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

DL # _____ Sex: _____ Martial Status: _____

Employer: _____ Email: _____

Person to contact in an emergency _____ Home # _____ Work # _____

If patient is a minor, give parent or guardian's name _____

Who may we thank for referring you to our office? _____

Dental Insurance Information

Insured's Name: _____ Relation to patient: _____

Insured's SS#: _____ DOB: _____

Insured's Address (if different than above): _____

City _____ State _____ Zip _____

Insured's Employer: _____ Insurance Company: _____

Claims Address: _____

Phone # _____ Group # _____ Effective Date of coverage: _____

The information above is true and correct to the best of my belief. I authorize any provider of services to furnish any information requested. I also hereby authorize my Dental Plan Administrator to release or obtain from my organization or person information that may be necessary to determine benefits payable under the group benefits with the Dental Benefit Plan. A Photostat copy of this authorization shall be considered as effective and valid as the original.

I understand that I am responsible for all of the charges for all services rendered to me or any member of my family. I understand an assessment of $50 will be charged to my account if I fail to cancel any appointment without at least 48 hours notice.

Although I have requested the dentist to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid within 45 days. If for any reason, my insurance company does not pay any portion of my bill, I further agree to make prompt payment of the bill.

I hereby authorize payment directly to the provider of the dental benefits otherwise payable to me:

Signed _____ Date _____

Kirstin Ramsay DDS
3311 PRESTON RD, SUITE 10 | FRISCO, TX 75034 | 972.668.7118 | INFO@PRESTONRIDGEDENTAL.COM

Preston Ridge Dental
Kirstin Ramsay, D.D.S.

Patient Name:_____ **Date:**_____

**** Please initial each section and sign on the final line if you agree. Thank you.*

Insurance Consent: I hereby authorize payment of insurance benefits directly to Dr. Ramsay, if we agree that Dr. Ramsay will take assignment of a claim. I authorize the release of any information relating to my dental claims to the insurance company so that they may process my claim. Our staff will make every effort to determine your exact out-of-pocket portion of the dental treatment you have agreed to. However, we are not able to guarantee what your insurance will pay. Every insurance company makes a disclaimer stating that they do not guarantee payment, and that a determination of benefits will not be made until the claim is received. While we have excellent results in general with our claims for dental benefits, your final balance may require modification once we receive the actual payment from your dental insurance. In some cases, insurance may deny any payment. The balance of your dental treatment is fully your responsibility. Please initial to indicate that you have read and understood this explanation.
Initials_____
I understand I am responsible for all charges for services rendered to myself or my dependants by Dr. Kirstin Ramsay. As a courtesy and at my request, Dr. Ramsay will process my insurance claims and submit them to my insurance carrier. If my insurance carrier does not pay any portion of the charges for any reason, I understand that I am responsible. Dr. Ramsay does not represent any insurance carrier and makes no representation as to what services will or will not be covered by my insurance carrier. If payment from the insurance company is not as it was represented to Dr. Ramsay's office, Dr. Ramsay is not responsible. Any disagreements I may have about which procedures have or have not been covered must be resolved directly with my employer or insurance carrier, but do not change my responsibility for all charges incurred. Any costs incurred in collecting a past due account will be my responsibility. ***Initials***_____

HIPPA Consent: Notice of Privacy Practices

I acknowledge that I have received and reviewed the office Privacy Policy Notice for Kirstin Ramsay, D.D.S.

Patients Printed Name:_____

Patients Signature:_____

In case you do not agree to sign this consent, our office must indicate why you decline to do so. Refusal to sign this form enables our ability to file your insurance claim for you.

Reason for patient's refusal:

_____

_____

Privacy Directors Signature:_____

Preston Ridge Dental
Kirstin Ramsay, D.D.S.

GENERAL DENTAL CONSENT FORM

Patient Name_____Date_____.

_____I authorize Dr. Ramsay to take dental x-rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. The costs of these services may or may not be fully covered by my third party insurance.

_____I understand that my treatment plan may be altered due to subsequent findings during the course of treatment. Incomplete or partial treatment may lead to problems, misunderstandings, and usually increased costs and progression of disease. Therefore, if a plan is started, it needs to be completed in a timely manner. Dr. Ramsay will do his best to design my treatment plan to fit my personal needs, while not compromising my dental health. In some instances this is not possible, and alternative treatments may need to be undertaken.

_____I understand that all responsibility for payment for dental services provided in this office for myself and my dependents is mine, and is due at the time services are rendered unless specific prior arrangments have been approved with this office. I am also responsible for any unpaid balances from my insurance company (if applicable) after 60 days. I agree to pay any attorney fees, or collection agency fees associated with the collection of this account.

_____I understand that my dental benefits may not cover certain procedures. We will attempt to find out an estimate of payment from your insurance company, but this is only an estimate. Failure of the insurance to pay for my treatment will result in direct billing to my account. Overpayment by insurance will be issued as credit for future services or reimbursed to you directly.

_____I will provide at least 24 hour notice of cancellation if I cannot keep my scheduled appointment. I understand a broken appointment fee of $50 may be assessed if proper notice is not given. I understand that multiple appointments will be grounds for dismissal.

_____I understand that an interpreter must be present for all patients that do not speak English. This allows for better communication in a native language for a healthy doctor/patient relationship.

_____I understand all original documentation and diagnostic aids are property of Dr. Ramsay and the practice. Records may not be taken from the office. I have a right to copies of these documents/records These records are confidential and may be copied only with written request from the patient. There may be a charge associated with copying records. These will be provided in a timely manner.

Patient Signature_____

Witness_____

Dental and Oral Health Information

Patient's name: _____ **Date:** _____

Please describe any specific dental problem or discomfort you are having at this time:_____

_____ How long has it been present? _____

If you have had any of the following dental care please list the dentists and approximate dates:

Periodontal (gum) treatment or surgery _____

"Braces" or any type of orthodontic treatment: _____

Dental implants:_____

Any other type of oral surgery: _____

Do you have / have you had / have you noticed any of the following signs or symptoms in your head, neck, or mouth?

(Please check Yes or No for each question)	Yes	No		Yes	No
Teeth that are sensitive to:			A clicking, snapping or difficulty when chewing	___	___
Hot, cold, sweets, or biting pressure	___	___	Difficulty opening or moving the jaws	___	___
An unpleasant taste or persistent bad breath	___	___	Difficulty speaking or changes in your voice	___	___
Does food catch between your teeth	___	___	Difficulty moving your tongue or "tongue tied"	___	___
Do your gums bleed when brushing	___	___	Loose or separating teeth	___	___
Red, swollen, tender, bleeding, or sore gums	___	___	Changes in the way your teeth fit together	___	___
Gums that have pulled away from the teeth	___	___	A color change of the tissues in your mouth	___	___
Pus between the teeth and gums	___	___	Pain, tenderness, numbness, or earaches	___	___
Avoid any area when brushing or chewing	___	___	Any lumps, swelling or swollen glands	___	___
You clench or grind your teeth	___	___	Sores, ulcers, or rough spots in your mouth	___	___

Your Dental Health:

How do you rate your overall dental health? £ Good £ Fair £ Poor

How many times a day do you brush your teeth? _____ How many times a week do you floss your teeth? _____

Do you use any of the following? (Please check Yes or No for each question)	Yes	No
Mechanical (electric) toothbrush If Yes, what type or brand? _____	___	___
Flossing aids (floss holders, threaders, etc.)	___	___
Oral irrigating device (Waterpik)	___	___
Fluoride treatments or supplements at home. If Yes, which ones: _____	___	___
Mouthwashes or oral rinses. If Yes, what brand? _____	___	___

Do you have any missing teeth that have not been replaced? ___ ___

Why have you not had them replaced? _____

Do you wear any removable dental appliances? ___ ___

If Yes, what type and for how long? _____

Have you ever had your teeth whitened or bleached? ___ ___

Would you like to have your teeth whitened or bleached? ___ ___

How do you feel about the appearance of your smile and what would you change if you could?

_____

Are you concerned about the finances required to return your mouth to excellent health? ___ ___

Are you frustrated because you always need something treated or repaired when you visit a dentist? ___ ___

Do you feel you will eventually wear artificial dentures? ___ ___

Have you ever had any complications from an extraction or dental treatment? ___ ___

If Yes, please explain: _____

Have you ever had any other dental conditions, major trauma or injury to your head, neck, or mouth**?** ___ ___

If Yes, please specify: _____

If you are a new patient to this practice:

Date of last dental visit_____ Dentist's name _____City & State_____

Reviewed By: _____

Health Information and History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

If you are completing this form for another person:

Your name: _____ Phone: _____ Relationship: _____

Emergency Contact: (If not listed above)

Name: _____ Phone: _____ Relationship: _____

Primary Physician: _____ Phone: _____ City & State: _____

Date of last physical examination: _____ Date of last blood test/work up: _____

Other Physicians & Specialists

Name: _____ Specialty: _____ Phone: _____ City & State: _____

Name: _____ Specialty: _____ Phone: _____ City & State: _____

1. With in the last 3 years, have you been hospitalized or had surgery? ☐ Yes ☐ No

If Yes, please give reasons and dates: _____

2. Have you ever been instructed to take ANY medications or take ANY special precautions before any dental appointments*? ☐ Yes ☐ No

If Yes, please explain: _____

3. Are you taking ANY drugs, medications, or treatments at this time? ☐ Yes ☐ No

(If you brought a complete written list with you, give that to the receptionist instead)

Prescribed: _____

_____

Over-the-counter (OTC) medications (such as Aspirin, Advil, allergy medication, sleeping aids, etc):

_____

Vitamins, natural or herbal preparations and/or dietary supplements:

_____

Are you having or have you ever had radiation or chemotherapy treatments*? ☐ Yes ☐ No

If Yes, for how long?_____ Name of facility performing the treatment :_____

4. Are you taking or have you ever taken / been treated with a Bisphosphonate (Fosamax)? ☐ Yes ☐ No

5. Are you allergic to or have you ever experienced an unusual reaction to:

___Latex ___Metals or jewelry ___Dental anesthesia (local)

___Fluoride ___Nitrous oxide (laughing gas) ___General anesthesia

6. Are you allergic to or have you ever had any reaction to any of the following drugs?

___Penicillin (or related drugs) ___Tranquilizers (Valium) ___Tetra cycline ___Codeine

___Aspirin / Ibuprofen (Advil, Motrin, Nuprin) ___ Keflex (Cephalexin) ___Sulfa drugs ___Iodine

___NSAID (Celebrex, Vioxx, Anaprox) ___ Clindamycin (Cleocin) ___Erythromycin

7. Have you had an allergic reaction or unusual response to ANY other medications, drugs, pills, or treatments? ☐ Yes ☐ No

If Yes, please list :_____

Continued on next page…

Reviewed By: _____

Health Information and History (continued)

Patient's Name: _____

8. Do you have, or have you ever had, any of the following? (Please check Yes or No for each question)

	Yes	No
Congenital heart defects	___	___
Angina or chest pains	___	___
Atherosclerosis	___	___
Congestive heart failure	___	___
Coronary artery disease	___	___
Heart surgery If Yes, type & date _____	___	___
Heart attack If Yes, date _____	___	___
Rheumatic heart disease / rheumatic fever	___	___
Infective Endocarditis*	___	___
Heart valve(s) damage / Mitral valve prolapse	___	___
Artificial heart valve	___	___
Pacemaker	___	___
Stroke or CVA	___	___
High blood pressure	___	___
Low blood pressure	___	___
Anemia	___	___
Hemophilia or bleeding disorder	___	___
Excessive bleeding from any cut or incident	___	___
Diabetes or blood sugar problems	___	___
Any artificial joint, joint surgery, or prosthesis If Yes, what join t or area: _____ When was operation done: _____	___	___
Hepatitis, jaundice, or other liver problems	___	___
Any form of cancer	___	___
An organ transplant	___	___

	Yes	No
Asthma	___	___
Hay fever, skin or food allergies or allergies in general	___	___
Sinus problems	___	___
Tuberculosis, emphysema or lung disorder	___	___
Skin problems	___	___
A sore or wound that bleeds easily or does not heal	___	___
A thyroid problem or disease	___	___
Arthritis	___	___
Glaucoma or any eye diseases	___	___
Epilepsy or other seizure disorder	___	___
Any kidney problems	___	___
Ulcers, acid reflux, or stomach problems	___	___
A compromised immune system (Lupus, HIV, AIDS, radiation immune problem, etc.)	___	___
An active sexually transmitted disease (STD)	___	___
Any mental health issues	___	___
Been treated for any psychiatric condition	___	___

Women Only:	Yes	No
Are you pregnant If Yes, what is your due date: _____	___	___
Do you think you might be pregnant	___	___
Are you presently nursing	___	___
Are you using birth control medication	___	___
Are you taking hormone replacement therapy	___	___

9. Do you have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know about, or that we should be made aware of? ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

_____

CONSENT — To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice.

I understand there are no guarantees or warranties in health or dental care.

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____

Oral Health Risk Factors

Patient's Name: _____

1. Do you smoke or have you EVER smoked? £ Yes £ No

(If No, proceed to question 2)

The amount that you are presently smoking (Check ALL that apply)

___None (quit smoking completely) ___Less than 1 pack of cigarettes per day ___An occasional cigar
___An occasional cigarette ___1-2 Packs of cigarettes per day ___Cigars on a daily / regular basis
___A few cigarettes per Day ___2 or more packs of cigarettes per day ___Occasional pipe smoker
___A pipe on a daily / regular Basis

If you have quit smoking, when did you quit?

___Less than 6 months ago ___6 months to a year ago ___1 to 3 years ago ___Over 3 years ago

How many years have you or did you smoke?

___Less than 2 years ___2-5 years ___5-10 years ___10-20 years ___Over 20 years

2. Do you / Have you EVER chew/chewed tobacco or use/used snuff or other similar substance? £ Yes £ No

(If No, proceed to question 3)

Are you STILL using smokeless tobacco or snuff? £ Yes £ No

If No, WHEN did you quit?

___Less than 6 months ago ___6 months to a year ago ___1 to 3 years Ago ___Over 3 years ago

How many years did you use or have you used smokeless tobacco?

___Less than 1 year ___1-2 years ___2-5 years ___Over 5 years

3. Approximate average amount of alcoholic beverages presently consumed per week:

___None ___Less than 1 per week ___1-5 drinks ___6-11 drinks ___11-20 drinks ___Over 20 drinks

4. Do you have or have you ever had a substance abuse problem? £ Yes £ No

Describe_____

5. Do you presently use any recreational drugs? £ Yes £ No

List_____

6. Do you have or have you ever had an eating disorder? £ Yes £ No

If Yes, Please Specify: _____

7. Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears) £ Yes £ No

List _____

8. Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)? £ Yes £ No

9. Please list your history or any family member's history of cancer:

_____

_____

10. Other concerns and considerations:

_____

_____

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care

Signature_____ Date _____

(Parent or guardian, if patient is a minor)

Reviewed By: _____