PLEASE PRINT - IN INK

PATIENT REGISTRATION - CHILD

PATIENT'S NAME _____
(LAST) (FIRST) (M.I.) (NICK NAME)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

PHONE ( ) _____ AGE _____ DATE OF BIRTH _____ SEX _____

SOCIAL SECURITY NUMBER _____

FATHER'S NAME _____ PHONE ( ) _____
(LAST) (FIRST) (M.I.)

HOME ADDRESS _____ CELL PHONE ( ) _____
(STREET) (CITY, STATE, ZIP)

FATHER'S EMPLOYER _____ HOW LONG? _____ OCCUPATION _____

EMPLOYER ADDRESS _____ BUSINESS PHONE ( ) _____
street city state zip

FATHER'S SOC. SEC. NO. _____ FATHER'S DATE OF BIRTH _____

PARENT'S MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

MOTHER'S NAME _____ PHONE ( ) _____
(LAST) (FIRST) (M. .I

HOME ADDRESS _____ CELL PHONE ( ) _____
(STREET) (CITY, STATE, ZIP)

MOTHER'S EMPLOYER _____ HOW LONG? _____ OCCUPATION _____

EMPLOYER ADDRESS _____ BUSINESS PHONE ( ) _____
street city state zip

MOTHER'S SOC. SEC. NO. _____ MOTHER'S DATE OF BIRTH _____

HAVE ANY OF YOUR OTHER CHILDREN BEEN SEEN IN OUR OFFICE? ☐ YES ☐ NO

IF YES, PLEASE LIST THEIR NAMES _____

NAME / ADDRESS OF NEAREST FRIEND OR RELATIVE WHO CAN BE REACHED IN AN EMERGENCY:

_____ ( ) _____
(NAME) (STREET ADDRESS) (CITY) (STATE) (ZIP) (PHONE)

RELATIONSHIP TO PATIENT _____

IS PATIENT COVERED BY DENTAL INSURANCE? ☐ YES ☐ NO

INSURANCE CO _____ INSURANCE CO. _____
SUBSCRIBER NAME _____ SUBSCRIBER NAME _____
EMPLOYER NAME _____ EMPLOYER NAME _____
ID/GROUP NO. _____ ID/GROUP NO. _____

METHOD OF PAYMENT: ☐ CASH ☐ CHECK ☐ CREDIT CARD (MASTERCARD/VISA)

OUR OFFICE POLICY IS AS FOLLOWS: THE PARENT WHO REQUESTS TREATMENT FOR THE CHILD IS RESPONSIBLE FOR ALL THE FEES FOR SERVICES RENDERED.

_____ _____
(SIGNATURE OF PARENT REQUESTING AND ACCEPTING FINANCIAL RESPONSIBILITY) (DATE)

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

HEALTH HISTORY

Patient's Name _____ **Date of Birth** _____ **Age** _____

Please answer the following questions below by checking the YES or NO box.

	YES	NO
1. Are you in good health?	☐	☐
2. Are you currently under medical treatment?	☐	☐
In yes, please explain. _____		
3. Have you ever been hospitalized or had a serious illness?	☐	☐
If yes, please explain _____		
4. Have you ever had excessive bleeding following an extraction, or had other bleeding problems?	☐	☐
5. **(WOMEN)** Are you pregnant? If yes, give due date	☐	☐
6. Do you use tobacco in any form? If yes, how much?	☐	☐
7. Do you use alcoholic beverages (more than 2 drinks per day)?	☐	☐

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING . . .

	YES	NO		YES	NO
Heart Trouble	☐	☐	Persistent, lingering or prolonged fevers	☐	☐
Heart Attacks	☐	☐	Hepatitis A B C (please circle)	☐	☐
Stents ____ Valve Replacement ____	☐	☐	Jaundice	☐	☐
High Blood Pressure	☐	☐	Arthritis ____ or Rheumatism ____	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐
Convulsions ____ or Epilepsy ____	☐	☐	Difficulty Breathing	☐	☐
Diabetes	☐	☐	Thyroid Condition ____ or Goiter ____	☐	☐
Rheumatic Fever	☐	☐	Radiation Therapy	☐	☐
Tuberculosis	☐	☐	Asthma ____ or Hay Fever____	☐	☐
Cancer	☐	☐	Nights Sweats	☐	☐
HIV Positive	☐	☐	Headaches	☐	☐
Fatigue, tiredness, or weakness within the past two years				☐	☐
Do you have any artificial joints? If yes, where_____ Pre Med Required?				☐	☐

ARE YOU ALLERGIC OR HAVE YOU EVER EXPERIENCED ANY REACTION TO THE FOLLOWING . . .

	YES	NO		YES	NO
Local Anesthetics (Like Novocaine)	☐	☐	Aspirin ___ or Codeine ____	☐	☐
Barbiturates / Sedatives / Sleeping Pills	☐	☐	Sulfa Drugs	☐	☐
Penicillin	☐	☐	Latex	☐	☐
Other Antibiotics _____	☐	☐	Other Allergies _____	☐	☐

ARE YOU TAKING ANY OF THE FOLLOWING . . .

	YES	NO		YES	NO
Antibiotics / Sulfa Drugs	☐	☐	Tranquilizers	☐	☐
Blood Thinners	☐	☐	Insulin / Diabetic Drugs	☐	☐
Blood Pressure Medication	☐	☐	Recreational Drugs	☐	☐
Thyroid Medication	☐	☐	Digitalis / Other Heart Medication	☐	☐
Cortisone / Steroids	☐	☐	Nitroglycerin	☐	☐
Allergy Medications	☐	☐	Aspirin	☐	☐

Other Medications (Please List) _____

List any other medical condition(s) or physical limitation we should be aware of _____

Physician's Name _____ Phone (___)_____

To the best of my knowledge, all of the preceding answers are true and correct.

Signature of Patient,

Parent, or Guardian: _____ Date: _____

DENTAL HISTORY

Patient's Name _____ **Date of Birth** _____ **Age** _____

DO YOU HAVE, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Bleeding, Sore Gums	☐	☐	Loose Teeth	☐	☐
Unpleasant Taste / Bad Breath	☐	☐	Sensitivity to heat, cold, sweets	☐	☐
Burning Tongue / Lips	☐	☐	Frequent Blisters, Lip/Mouth	☐	☐
Swelling / Lumps in Mouth	☐	☐	Sensitivity to Biting	☐	☐
Biting Cheeks / Lips	☐	☐	Clenching / Grinding	☐	☐
Clicking / Popping / Pain in Jaw	☐	☐	Change of Bite	☐	☐
Orthodontic Treatments (Braces)	☐	☐	Periodontal Treatment (Gum Surgery)	☐	☐
Dental Implants	☐	☐	Whitening	☐	☐

Date of Last Dental Visit _____

DO YOU USE THE FOLLOWING:

	YES	NO
Brush	☐	☐
Dental Floss	☐	☐
Fluoride Rinses	☐	☐

How often do you brush?_____

Brush is Soft ____ Medium ____ Hard ____

DO YOU LIKE THE APPEARANCE OF YOUR SMILE? YES ☐ NO ☐ If not, why_____

WHAT ARE YOUR OTHER DENTAL CONCERNS? _____

_____

_____

TO BE FILLED OUT FOR CHILDREN 12 YEARS OF AGE OR YOUNGER:

	YES	NO
Is this your first dental visit?	☐	☐
Have there been unpleasant medical or dental visits?	☐	☐
Is there a finger sucking habit?	☐	☐
Have there been any injuries to the mouth / teeth / head?	☐	☐
Have there been fluoride treatments?	☐	☐
Does your child brush daily?	☐	☐
Do you assist your child with tooth brushing	☐	☐
How often? _____		
Do you desire complete dental service for the child?	☐	☐

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.

Signature of Patient,
Parent, or Guardian: _____ Date: _____

Ridgewood Dental P.C.

7777 E. Ridge Road Suite A Hobart, IN 46342
(219) 947-2922 Fax (219) 942-1876

Financial Responsibility

I _____ (Responsible Party) agree, I am financially

responsible for _____ (Patient's Name) dental treatment provided by Ridgewood Dental P.C. I also agree I am responsible for a monthly finance charge of 1.75% MPR, which will be added to balances more than 30 days old ($10.00 minimum). If collection action is initiated on my account, I agree I am responsible for all fees, attorney fees and all court costs incurred by Ridgewood Dental P.C.

(Delinquent accounts may be reported to the credit bureau and may affect your credit rating).

Signed _____ Date _____

I give consent to Ridgewood Dental P.C. to send any necessary reminders concerning appointment or needed treatment.

Signed _____ Date _____

Insurance Authorization

I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to:

RIDGEWOOD DENTAL P.C.

A copy of this can be considered an original for insurance purposes.

I acknowledge and understand I am responsible for all charges for all services rendered to me or any member of my family.

I further understand my insurance company may pay only usual and customary fees which are not acceptable to the doctor and therefore are my responsibility to pay.

Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand it is still my responsibility to make sure the bill is paid in a reasonable time. if for any reason any portion of my bill is not paid for by my insurance, I further agree to make arrangements for prompt payment of the bill.

Signed _____ Date _____

Ridgewood Dental P.C
7777E Ridge Rd. Suite A Hobart, IN 46342
(219)947-2922 Fax (219)942-1876

Our practice is passionate about your dental health and takes pride in providing you with the best care possible. Our team will take time to discuss our professional fees and financial options with you that will allow you to make informed decisions regarding your dental treatment and select a Financial Arrangement that is affordable for you. Your clear understanding of our Financial Arrangement Form is very important to our professional dental relationship. If you have any questions, or concerns, please do not hesitate to ask.

Payment Is due and payable at the time of services are rendered. For your convenience, we accept Cash, Personal Checks (Indiana Only), Visa, Master Card, Discover card, and CareCredit.

All methods of payment must be in the name of Financially Responsible Party.

Payment plans/Financial Arrangements

- **10% courtesy-** You can take advantage of our courtesy if you pay your balance in full at time of service by **cash** or **personal (INDIANA) check only.** This is extended to patients with **NO Dental Insurance.**
- **No Interest Financing-** We now offer a financing option through CareCredit. This option offers no interest payment plans with affordable low monthly payments. Easy to apply online or by phone.
- An account service charge will be assessed each billing period on all balances 30 days past due ($10.00 Minimum)

Dental Insurance- If you have dental insurance to help you with your payment, please submit a photocopy of your insurance card and your dental benefits booklet, if available. We cannot bill your insurance company until we receive your insurance information. As a courtesy, we will process your insurance claim. However, we do require your estimated payment to be paid on the day of your visit. (Your deductible and/or co-payment) The balance incurred is your responsibility whether your insurance company pays or not. Coverage amounts vary from policy to policy, and our office cannot guarantee the amount of coverage offered by your insurance carrier. Please understand your insurance policy is a contract between you and your insurance company. Any excess monies collected by our practice will be refunded to you once we receive the insurance check or in case of underpayment by your insurance company the remaining will be due within 30 days. I hereby authorize any insurance company to pay the proceeds of any benefits due me directly to; Ridgewood Dental P.C., I acknowledge and understand I am responsible for all changes for all services rendered to me or any member of my family. A copy of this can be considered an original for insurance purposes.

Broken Appointments- In our practice an appointment reserved by you is confirmation that you are committed to your treatment as our team of Doctors and Hygienists are committed to taking care of your treatment needs. We realize emergencies do arise, but repeated broken appointments will necessitate us to ask you to call the office on a day you are available to have treatment. Please note if you arrive after your scheduled appointment time, we will do our best to accommodate you.

Collection Policy – Collection action will be taken on any unpaid balance. If collection action is initiated on my account, I Agree I am responsible for all fees, attorney fees and all court costs incurred by Ridgewood Dental P.C Delinquent accounts may be reported to the credit bureau and may affect your credit rating.

I hereby acknowledge receipt of the above payment options and financial responsibilities

Print name_____

Signature_____ Date_____

Leonard W. Ostrowski III, D.D.S.
Robert B. Ray, D.D.S., F.A.G.D.

Ridgewood DENTAL P.C.

7777 E. Ridge Road
Hobart, IN 46342

Phone: (219) 947-2922 Fax: (219) 942-1876
www.RidgewoodDentalCenter.com

Patient Consent for Use and Disclosure of PHI and NPP Receipt

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by Ridgewood Dental P.C., in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information. The Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient. _____

_____

_____

_____

_____effective until (Date) _____.

_____

This Organization will utilize the patients address and telephone numbers for communications.

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

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KMcLendon

This Organization has published a HIPAA 'Notice of Privacy Practices' (NPP). I have been informed and provided a copy of the NPP. Please check one item below:

_____ NPP Provided

_____ NPP Previously Provided

_____ NPP Declined

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____

Print Name

_____ _____ _____

Patient or Legally Authorized Representative **Date** **Time**

_____ _____ _____

Relationship to Patient If Signed By Another Party **Date** **Time**

Please explain Patient's Representative Relationship to the patient and include a description of the Representatives authority to act on behalf of the patient.

_____

_____

_____

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