RYAN M. ROSS, D.D.S. CONFIDENTIAL

Patient Registration Information

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out the form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance- we will be happy to help!

Name_____ Date_____
First Mi. Last
Home Address_____ City_____ State_____ Zip_____
Birthdate_____ Home Phone_____ Work Phone_____ Cell Phone_____

Do you prefer to receive calls at: ☐ Home ☐ Cell (☐ Text) **Email** _____

Are You: ☐ Minor ☐ Single ☐ Married ☐ Domestic partner ☐ Separated ☐ Divorced ☐ Widowed

Employer_____ Occupation_____ **Drivers LICENSE #** _____

Your Spouse or Parent's Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Second Contact _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party

Name of person responsible for this account_____ Relationship _____
Address_____ City _____ State _____ Zip _____
Home Phone_____ Work Number_____ **Drivers LICENSE #** _____

Insurance Information

Name of insured _____ Birthdate _____ Relationship to patient_____
Address of insured_____ City _____ State _____ Zip _____
Employer _____
Insurance company _____ Phone# _____
Policy/Subscriber # _____ Group # _____

Authorization, Release, and Agreement to Pay For Services Rendered

I authorize and hereby request my insurance company to pay insurance benefits directly to the dentist.
I understand that my dental insurance carrier may pay less then the actual bill for services.
I agree to be responsible for payment of all services rendered on my behalf and of my dependents

_____
Signature of patient or parent/guardian of minor Date

Unless arrangements are made prior to the appointment <u>payment is expected at time of service</u>; or in case of insurance coverage, the patient share is due at time of service.
For your convenience,we offer the following methods of payment ■ Cash ■ Check ■ Mastercard ■ Visa ■ Discover
Prepayment of a **TREATMENT** plan with a check or cash at or before the next visit receives a **5% discount.**

Late Appointment Policy: 10 minutes or more may require the appointment to be rescheduled (____) Initial.

● Missed Appointment Policy ●

There will be a $65.00 charge for the second missed appointment without 24 hours notice____ (initial).

(CONFIDENTIAL)

Patient's Name _____ Date_____

DENTAL HISTORY

Reason for Today's Visit_____
Former Dentist_____ __Phone ( )_____
Date of Last Dental Visit _____Date of Last Dental X-rays_____
Check if you have had problems with any of the following

☐Bad Breath	☐Grinding teeth	☐ sensitivity to hot
☐Bleeding gums	☐periodontal treatment	☐ Sensitivity to sweets
☐Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity when biting
☐Food collection between teeth	☐ sensitivity to cold	☐ Sores or growths in your mouth

Does dental treatment make you apprehensive?..... ☐no ☐slightly ☐ extremely
Are you nervous about today's visit?..... ☐no ☐slightly ☐ extremely

MEDICAL HISTORY

Physician's Name(Medical Doctor)_____Date of last visit_____
Have you had any serious illnesses or operations?_____ If yes, describe_____
(Women)Are you pregnant? ☐yes ☐no Nursing? ☐yes ☐no Taking birth control pills? ☐yes ☐no

Check ✔

yes	no		yes	no		yes	no		yes	no	
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	HIV Positive	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Eating Disorders	☐	☐	Jaw Pain	☐	☐	Shortness of Breath
☐	☐	Artificial Heart valves	☐	☐	Epilepsy or seizures	☐	☐	Jaundice	☐	☐	Sinus Infections
☐	☐	Artificial Joints	☐	☐	Fainting/Dizziness	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Asthma/Hay fever	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Swelling of limbs
☐	☐	Back Problems	☐	☐	Headache (frequent)	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Heart Murmur	☐	☐	Nervous Problems	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Heart problems	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Chemotherapy			describe _____	☐	☐	Phen phen(diet drugs)	☐	☐	Tumors
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Psychiatric care	☐	☐	Tuberculosis
☐	☐	Coldsores/fever blisters	☐	☐	Prolonged bleeding	☐	☐	Radiation Treatment	☐	☐	Ulcers
☐	☐	Cortisone Treatment	☐	☐	Hepatitis A, B or C	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever			

Do you require a preventative antibiotic before dental treatment? ☐yes ☐no

MEDICATIONS	ALLERGIES
List of medications you are currently taking: _____ _____ Pharmacy Name_____	☐ Aspirin ☐ Penicillin ☐ Barbiturates(sleeping pills) ☐ Sulfa ☐Codeine ☐ Other_____ ☐ Local Anesthetic _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I made in the completion of this form.

Date_____Signature_____