Smile Assessment Form

Please consider each statement carefully and circle YES or NO. The doctor and team members will be happy to discuss your responses with you in confidence.

The most important concerns regarding my dental treatment are: ______________________________________

____

What factors are most important for your satisfaction with our office?__________________________________

____

I am uncomfortable showing my teeth when I smile	yes	no
I am unhappy with my crowns or fillings	yes	no
My gums or teeth are sensitive	yes	no
I am concerned that my gums are receding	yes	no
I clench or grind my teeth	yes	no
I have questions about the benefits of dental benefits	yes	no
I am unhappy with the appearance of my teeth	yes	no
I feel that my teeth could be whiter	yes	no
I am interested in straightening my teeth	yes	no
I feel my teeth are too long or too short	yes	no
I am anxious or fearful of treatment	yes	no
Is there something else holding you back from the Perfect smile? (Explain below)	yes	no

Any additional concerns/comments?____

CONSENT TO PROCEED

I authorize the doctor(s) of Ridge View Dental and such associates, or assistants as they might designate to perform those procedures as may be deemed necessary, or advisable to maintain my dental health, or the dental health of any minor, other individual for which I have responsibility. This includes arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic, or surgical treatments.

I understand that the administration of local anesthetic may cause untoward reaction or side effects, which may include, but are not limited to: brushing, hematoma, cardiac stimulation, and temporary, or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventative procedures such as cleaning and basic dentistry including filling of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointment, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or the oral tissue to be inadvertently abraded or lacerated during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician, or hospital and may in rare cases, required bronchoscope, or other procedures to ensure the safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis may result in complication of non-healing of the jaw bones following oral surgery.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results; which may or may not be achieved for my benefits, or the benefits of a minor or other individual responsible for. I acknowledge that the nature and purpose of the foregoing procedure have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name: ____

Signature: ____ Date: ___________________

(Patient, Legal guardian, or authorized agent of patient)

Patient Information

Patient Name Gender: M F Family Status: M S C

Birthdate SSN E-Mail Address

Home Phone Work Phone Cell Phone

Address City, State, Zip

Emergency Contact (Not currently living with you) Relationship to Patient

Address City, State, Zip PHONE #

How did you hear about our office?

Dental Insurance Information

Primary Insurance

Subscriber Name Birthdate SSN

Address City, State, Zip

Patient's Relationship to Subscriber: Self Spouse Child Other

Name of Insurance Company ID# Group #

Insurance Address City, State, Zip

Subscriber's Employer

Secondary Insurance

Subscriber Name Birthdate SSN

Address City, State, Zip

Patient's Relationship to Subscriber: Self Spouse Child Other

Name of Insurance Company ID# Group #

Insurance Address City, State, Zip

Subscriber's Employer

Responsible Party Information

Only fill out if the above patient is under 18

The responsible party is the parent/legal guardian who will be signing the in-office documents

Responsible Party's Name Gender: M F Family Status: M S C

Birthdate SSN E-Mail Address

Home Phone Work Phone Cell Phone

Address City, State, Zip

Employer employer Phone

Medical History Information

1. Have you been a patient in the hospital during the past two years? ☐Yes ☐No
2. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No

Physician's Name____Phone Number ______________________

3. Have you taken any medication or drugs in the past two years? ☐Yes ☐No
4. Are you now taking any medication or drugs? (includes medication for pain, marijuana, and hormones) ☐Yes ☐No

If yes, please list:____

____

5. Are you sensitive or allergic to any medication or anesthetics? ☐Yes ☐No

If yes, please list:____

____

6. Have you ever taken the diet drug Phen-Phen? ☐Yes ☐No

Indicate which of the following you have had or have at the present. Check "yes" or "no" for each item.

Condition		Condition		Condition	
A.I.D.S	☐Yes ☐No	Diabetes	☐Yes ☐No	Hypoglycemia	☐Yes ☐No
Allergies or Hives	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Kidney Trouble (dialysis)	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Emphysema	☐Yes ☐No	Liver Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No
Angina Pectoris	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	*Mitral Valve Prolapse	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting or Dizzy	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No
Arteriosclerosis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Radiation Therapy	☐Yes ☐No
*Artificial Joints (hip, knee, etc.)	☐Yes ☐No	Hay Fever	☐Yes ☐No	*Rheumatic/ Scarlet Fever	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Heart Disease/Attack	☐Yes ☐No	Rheumatism	☐Yes ☐No
Arthritis	☐Yes ☐No	Heart Surgery	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Blood Disease	☐Yes ☐No	*Heart Pacemaker	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Breathing Problems	☐Yes ☐No	Heart Failure	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Bruise Easily	☐Yes ☐No	*Heart Murmur	☐Yes ☐No	Stroke	☐Yes ☐No
Cancer	☐Yes ☐No	Hepatitis B (serum)	☐Yes ☐No	STD	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hepatitis A (infectious)	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Chronic Cough	☐Yes ☐No	Hepatitis C	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Congenital Heart Disease	☐Yes ☐No	Hemophilia	☐Yes ☐No	Tumors	☐Yes ☐No
Cortisone Medicine	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Ulcers	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	H.I.V. Positive	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Developmentally Disabled	☐Yes ☐No	Herbal Supplements	☐Yes ☐No		

7. Do your ankles swell during the day? ☐Yes ☐No
8. Have you lost or gained more than 10 pounds in the past year? ☐Yes ☐No
9. Do you have or have you had any disease, condition, or problem not listed? ☐Yes ☐No

If yes, please list:____

10. Do you use tobacco products? ☐Yes ☐No
11. Do you use alcohol products? ☐Yes ☐No

FOR WOMEN ONLY:

12. Are you pregnant? ☐Yes ☐No If yes, what month? ___________________ Are you nursing? ☐Yes ☐No
13. Are you taking birth control pills? ☐Yes ☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. In the event of non-payment for dental services received, the undersigned agrees to pay all lawyer fees, court costs, and collection fees up to 50%, if turned over to a outside collection agency.

PATIENT SIGNATURE____ DATE______________________________

FINANCIAL AND INSURANCE POLICIES

Thank you for choosing us as your dental care provider. We are anxious to serve you and are committed to providing the best care possible. Payment is due at time of treatment. In order to make your dental care financially comfortable, we offer the following financial options. Please circle the option(s) that will be the most comfortable for you:

- **Payment in Full Courtesy.**
  A prepayment courtesy of 10% will be subtracted from the total patient obligation if the patient obligation is **paid in full.** *We accept Cash, Visa, MasterCard, Discover, American Express, Money Order, Personal Checks*
- **Outside Financing.**
  Our office uses CareCredit® for flexible payment options. We have options ranging from 6 to 12 months interest free financing based on the amount of dentistry financed. Approval must be received prior to treatment date
- **No Dental Insurance Discount (20% with the In-office Dental Plan).**
  Patients without dental insurance will be given a 20% when they sign up for the Ridge View Dental Plan (ask for details). This offer cannot be combined with the "Payment in Full Courtesy" listed above.

Please initial our Financial Policies Below

INSURANCE POLICY

__________ Insurance benefit coverage depends solely on what your employer wishes to purchase. **The financial obligation for dental treatment is between you and our office. The insurance company is responsible to you, and not to our office.** We will assist you in any way we can. Any amount owing after your insurance company has paid will be due from you upon receipt of our statement. If for any reason we have not received your insurance carrier's payment 90 days after the claim was submitted, the remaining balance will be due and payable by you and subject to 18.5% APR. Should the account be referred to an attorney or collection agency, I will pay all cost of collection, including up to 30% collection fee, as well as court costs and a reasonable attorney fee.

AUTHORIZATION FOR SIGNATURE ON FILE

__________ I, hereby authorize **Ridge View Dental** to affix my name to any and all claims and documents as related to any and all health benefits due me and my dependents. To the extent permitted under applicable law, I authorize release of any information relating to the claim. I hereby authorize payment of health benefits, otherwise payable to me, directly to the office listed above. I agree to be responsible for all charges for services and materials not paid by my health benefit plan. A photocopy of this document may act as an original. I also authorize **Ridge View Dental** to contact my insurance company by email communications or me by text messaging regarding my appointments.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY (HIPPA)

__________ I have reviewed a copy of the Office's Privacy Policies.

LONG APPOINTMENT DEPOSITS

__________ To provide the absolute best care to our patients, certain procedures take longer than others. Because of this, a deposit of either $100 or 10% of the total appointment value will be required to secure those types of appointments.

CANCELLATION AND NO-SHOW POLICY

__________ Due to the number of patients requiring treatment, **Ridge View Dental** is now implementing a fee for cancellations with less than **48 hours'** notice or if you do not show up for a scheduled appointment.

- General Dentist & Hygiene Appointments = $50.00/per hour

These fees will be posted to your patient ledger if you cancel an appointment within a 48-hour period or if you no-show your appointment.

__________ **I also understand that Ridge View Dental will move my appointment(s) off the schedule after 3 attempts to confirm my appointment(s) without a returned call or confirmation from the patient or parent of the patient, if a minor.**

By signing below, I understand the Financial and Insurance Policies, Authorization for Signature on File, the Acknowledgement of Receipt of Office Privacy Policy, the Long Appointment Deposits, and the Cancellation and No-show Policy of **Ridge View Dental** and have had any and all questions answered to my satisfaction.

____________________ Print Patient Name

____________________ Signature (Parent or Guardian if Minor)

____________ Date