

# HEALTH HISTORY & REGISTRATION

**WELCOME TO OUR OFFICE!** We do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. It is important to know your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to complete BOTH SIDES of this form.

Last, First, M. Name: \_\_\_\_\_ Sex: M F Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
 Please indicate one: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Your Soc. Sec. # \_\_\_\_\_  
 Are you a full time student? \_\_\_\_\_ If yes where?: \_\_\_\_\_  
 Name of Spouse \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 If patient is a minor we need: Mother's Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Father's Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 Person responsible for account: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

### EMPLOYEE INFORMATION

Employee Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long employed: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Contact Name: \_\_\_\_\_

### EMERGENCY INFORMATION

Name of Nearest Relative (Not Living With You) \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## FAMILY MEMBER INFORMATION

	FIRST NAME	LAST NAME	SEX	RELATIONSHIP* I - S - C - O	BIRTHDATE		
					M	D	Y
(1.)	_____	_____	_____	_____	_____	_____	_____
(2.)	_____	_____	_____	_____	_____	_____	_____
(3.)	_____	_____	_____	_____	_____	_____	_____
(4.)	_____	_____	_____	_____	_____	_____	_____
(5.)	_____	_____	_____	_____	_____	_____	_____
(6.)	_____	_____	_____	_____	_____	_____	_____

Please list additional members on reverse. \*I = Insured S = Spouse C = Child O = Other Dependent

### FILL OUT REMAINDER ONLY IF USING INSURANCE.

DENTAL INSURANCE INFORMATION (Primary Carrier)	(SECONDARY COVERAGE)
Insured's Name _____	If you have double dental insurance coverage complete this for the second coverage.  Insured's Name _____ Insurance Co. _____ Insurance Co. Address _____ Insured's Employer _____ Insured's Soc. Sec. # _____ Group # _____ Local # _____
Insurance Co. _____	
Insurance Co. Address _____	
Insured's Employer _____	
Insured's Soc. Sec. # _____ Group # _____ Local # _____	
Does this plan cover all family members? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, Please Specify members NOT covered by plan. _____ _____	

### CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids necessary to make a thorough diagnosis of the patient's dental needs. I also authorize any and all forms of treatment, medication and therapy, which may be deemed necessary in the best interest of the patient's health.

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_

### RESPONSIBILITY OF ACCOUNT:

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. All outstanding account balances over 60 days will bear a charge of 1 1/2% per month (18% per year) from the date the fees are charged until they are paid in full. It is our office policy to bill your insurance carrier as a courtesy to you, although YOU are responsible for the entire balance. Once the insurance is billed, we will set aside that portion of the balance estimated to be paid by your carrier for 60 days. If your carrier does not remit payment within 60 days, the balance will be due from you, unless other arrangements are made. I further understand that a finance charge, attorney's fees, collection fees and court cost will be added to any overdue balance.

I authorize payment of insurance benefits to David Ricks, D.D.S., P.C.

Patient Signature (Parent of Child) \_\_\_\_\_ Date \_\_\_\_\_