WELCOME

We would like to take this opportunity to welcome and thank you for joining our dental practice. We appreciate your confidence in us and we will do everything possible to provide you with the finest dental care. Please fill out these forms completely. The better we communicate, the better we can care for you.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

About You

Today's Date: _____ (Month / Day / Year)

Social Security #: _____

Name: _____ (Last / First / Middle Initial)

I like to be called: _____

Home Address: _____

_____ (Apt/Condo # / City / State / Zip Code)

Mailing Address, If Different:

Address: _____

_____ (City / State / Zip Code)

Your Employer: _____

Occupation: _____ How long held: _____

Birthday _____ (Month / Day / Year) ❑ Male ❑ Female

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Special interests, sports or hobbies: _____

_____

Referred by: _____

Telephone

Home Phone: _____

Work Phone: _____ Ext. #: _____

Beeper or car phone: _____

When is the best time to reach you? _____

Where? _____ Spouses employers' phone #: _____

In the event of an emergency, is there someone who lives near you that we could contact? _____

Name: _____ Relationship: _____

Work #: _____ Home #: _____

Dental Benefits

Do you have dental benefits through your employer?

❑ Yes ❑ No

If yes, please provide the following information:

Dental Benefit Plan #1: _____

Group #: _____ Carrier Phone #: _____

Carrier Address: _____ (City / State / Zip Code)

Your Employer's Name: _____

Employer Address: _____

Do you have any other Dental Benefit Coverage?

❑ Yes ❑ No

This coverage is through: ❑ Spouse ❑ Parent

❑ Other: _____

Their Name: _____

Their Employer's Name & Address: _____

_____

Their Social Security #: _____

Their Birthdate: _____ (Month / Day / Year)

Dental Benefit Plan #2: _____

Group #: _____ Carrier Phone #: _____

Carrier Address: _____ (City / State / Zip Code)

Release of Information

I authorize the release of any dental information necessary to process my claims.

Signature: _____

Assignments of Benefits

I authorize payment directly to: _____ of the group insurance benefits otherwise payable to me.

Signature: _____

MEDICAL HISTORY

Personal Physicians Name: _____

Address: _____

Phone #: _____

The approximate date of your last doctors visit: _____

Your current physical health is:

❑ Good ❑ Fair ❑ Poor

Are you currently under the care of any physician?

❑ Yes ❑ No If yes, please explain: _____

_____

Do you smoke or use tobacco in any other form?

❑ Yes ❑ No

Are you presently taking any drugs prescribed by a physician or dentist? ❑ Yes ❑ No If yes, please list:

_____

_____

For women: Are you pregnant? ❑ Yes ❑ No

Do you need to be premedicated before dental treatment? ❑ Yes ❑ No

Have you had any serious medical problems in the last 5 years? ❑ Yes ❑ No If yes, please explain: _____

_____

_____

_____

Have you ever had any of the following diseases or medical problems?

Y N Heart Attack/Stroke	Y N Cancer/Chemotherapy
Y N Heart Murmur/Rheumatic Fever	Y N HIV+/AIDS
Y N Heart Surgery/Pacemaker	Y N Shingles
Y N Chronic Hepatitis	Y N Kidney problems
Y N Anemia	Y N Sinus problems
Y N High/Low Blood Pressure	Y N Fever Blisters
Y N Severe Headaches	Y N Psychiatric problems
Y N Epilepsy/Seizures/Fainting Spells	Y N Diabetes
Y N Drug/Alcohol Abuse	Y N Tuberculosis (TB)
Y N Hemophilia/Abnormal Bleeding	Y N Sickle Cell Disease

OFFICE USE ONLY: Doctor's Comments: _____

_____

_____

Any other serious medical conditions:

Have you experienced any that are not listed above?

❑ Yes ❑ No If yes, please list: _____

_____

_____

_____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Aspirin
Y N Erythromycin	Y N Tetracycline
Y N Dental Anesthetics	Y N Codeine

Are you allergic to any other drugs? ❑ Yes ❑ No

If yes, please list: _____

_____ _____

DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Are you under any unusual stress at home or work?

❑ Yes ❑ No

Do you experience stress or anxiety when you visit a dental office? ❑ Yes ❑ No

The approximate date of your last dental visit: _____

Have you ever experienced TMJ problems?

❑ Yes ❑ No

(TMJ is pain or discomfort in your jaw joints.)

Do you grind your teeth? ❑ Yes ❑ No

Your current dental health is:

❑ Good ❑ Fair ❑ Poor

Do you like your smile? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Would you like to prevent dentures? ❑ Yes ❑ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Additional Notes: _____

_____

_____

_____

_____

CHILD
PATIENT REGISTRATION
AND HEALTH HISTORY

Welcome!

ABOUT YOUR CHILD

Name: _____
Last First Mid

Nickname _____

Birthdate _____ ☐ Male ☐ Female
Month Day Year

Social Security # _____

School: _____

Address: _____

Phone _____

Home Address _____

_____
Apt/Condo # City State Zip Code

Home phone: _____

Referred By: _____

ABOUT YOU

Your Name _____

Social Security # _____

Relationship to child _____

Your home phone and address if different from child's: _____
Home Phone

_____
Address

_____
Apt/Condo # City State Zip Code

Occupation _____

Employer _____

Work phone _____ Ext. _____

Beeper/Car phone _____

DENTAL INSURANCE

Dental Ins. Co.: _____

Their phone _____

Group # _____

This Dental Insurance is provided through:

Their name: _____

Relationship to child _____

Their Social Security #: _____

Their birthdate _____

Their employer: _____

Dental Ins. Co.: _____

Their phone _____

Group #: _____

This Dental Insurance is provided through:

Their name _____

Relationship to child: _____

Their Social Security # _____

Their birthdate _____

Their employer: _____

Please continue on back...

DENTAL/MEDICAL HISTORY

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, the approximate date of last visit: _____

Are there any dental problems that you are aware of or present? ☐ Yes ☐ No If yes, please explain: _____

_____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Please rate your child's oral health: ☐ Good ☐ Fair ☐ Poor

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's physician: _____

Their phone #: _____

The approximate date of last visit? _____

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor

Is your child allergic to any drugs? ☐ Yes ☐ No

If yes, please list: _____

Is your child taking any prescription drugs? ☐ Yes ☐ No

If yes, please list: _____

Does your child need to be premedicated before dental treatment? ☐ Yes ☐ No

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Has your child ever had any of the following medical conditions or problems?

Please circle:

Y N Heart Murmur

Y N Heart problems of any kind

Y N Convulsions/ Epilepsy

Y N Cancer

Y N Diabetes

Y N Rheumatic Fever

Y N HIV +/AIDS

Y N Hemophilia

Y N Bleeding problems of any kind

Y N Hearing impairment

Y N Hyperactive

Y N Any Operations

Y N Any stays in hospital

In the event of an emergency, who should we contact:

Name _____ Relationship: _____

Phone _____ Phone #2: _____

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No

If yes, please list: _____

_____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I consent to have my insurance company billed directly.

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Signature of parent or guardian _____ Date _____

THANK YOU

Dr. Rieker's Financial Policy for **Insured Patients**

Dear Insured Patient or Parent/Guardian of Insured Patient:

Thank you for choosing our practice to provide for your dental needs. You have indicated to us you have the good fortune to be covered by some form of dental/health insurance. To avoid the misunderstandings that occasionally occur, we wish to clarify our policies and procedures relating to the handling of your insurance claim.

Insurance is designed to help pay part of the cost of dental treatment. Your employer has made this contract available to you and we will do our best to help you maximize its benefits. Dental insurance is NOT designed to pay the entire cost of treatment, but rather to assist you in paying for that treatment. Your insurance contract is between you, your employer, and the insurance company. The type of benefits in your contract depends upon what your employer has negotiated with the insurance company and the amount of money paid in premiums. There is no direct relationship between our office and your employer, labor union, or insurance carrier.

You are contracting for our services and are entitled to only the highest quality dental care we can render in a pleasant environment. We are entitled to prompt compensation for services provided to you.

As a courtesy service to our patients, we will complete an approved insurance claim form and forward it to your primary and/or secondary insurance carriers as appropriate. Your portion of the fees will be APPROXIMATED at the time of your appointment and this amount is due at the completion of that visit. *We accept cash, checks with proper i.d., money orders, and Discover/MasterCard/Visa.* There will be a $25.00 fee for returned checks. Disputes as to coverage, treatment plans, etc. are strictly between you and your insurance company. It would be to your advantage for you to check your policy prior to treatment for covered benefits. You, as the patient, are ultimately responsible for all charges for services rendered through our office. When significant amounts of dental treatment are involved, we will, upon your request, submit the information to your insurance company for pre-authorization. Submission of the pre-authorization form does not in any way obligate you to any part of the proposed treatment plan.

NO SHOW/LATE POLICY: Our goal is to accommodate our patients' health care needs and their schedule as well as schedule them in a timely fashion to the best of our ability. For this reason, we require a 24-hour notice of cancellation, so that your appointment time may be offered to another patient. A $50.00 cancellation fee may be charged if you fail to cancel 24-hours in advance of your appointment. Your appointment may be rescheduled for a later date if you are more than 15 minutes late for your appointment.

OVERDUE ACCOUNTS: For balances greater than 30 days old finance charges at the rate of 1.5% monthly (18% annually) will accrue or a monthly billing charge of $2.00 will apply, depending upon which is greater. I understand in special circumstances, I have the option to use a finance company (upon approval), for which I will pay no or minimal interest. I realize that failure to keep this account current may result in Dr. Rieker being unable to provide additional dental treatment except for dental emergencies or where there is prepayment for additional services. If payment ceases and no effort is made to bring account balance current, third party collection assistance will be utilized. In the case of default on this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balance. **Date:**_____
Signature of Insured Patient or Parent/Guardian:_____

Thank you for understanding this Financial Policy. Please let us know if you have any questions or concerns.

Dr. Rieker's Financial Policy for **Non-Insured Patients**

Dear Patient or Parent/Guardian of Patient:

Thank you for choosing our practice to provide for your dental needs. You are contracting for our services and are entitled to only the highest quality dental care we can render in a pleasant environment. We are entitled to prompt compensation for services provided to you. **Payment in full is due at the time of service.** For your convenience, *we accept cash, checks with proper i.d., money orders, and Discover, MasterCard, or Visa.* There will be a $25.00 fee for returned checks.

NO SHOW/LATE POLICY: Our goal is to accommodate our patients' health care needs and their schedule as well as schedule them in a timely fashion to the best of our ability. For this reason, we require a 24-hour notice of cancellation, so that your appointment time may be offered to another patient. A $50.00 cancellation fee may be charged if you fail to cancel 24-hours in advance of your appointment. Your appointment may be rescheduled for a later date if you are more than 15 minutes late for your appointment.

OVERDUE ACCOUNTS: For balances greater than 30 days old finance charges at the rate of 1.5% monthly (18% annually) will accrue or a monthly billing charge of $2.00 will apply, depending upon which is greater. I understand in special circumstances, I have the option to use a finance company (upon approval), for which I will pay no or minimal interest. I realize that failure to keep this account current may result in Dr. Rieker being unable to provide additional dental treatment except for dental emergencies or where there is prepayment for additional services. If payment ceases and no effort is made to bring account balance current, third party collection assistance will be utilized. In the case of default on this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this account or any future outstanding account balance.

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

Thank you for understanding this Financial Policy. Please let us know if you have any questions or concerns.