



STEPHEN RATCLIFF

FAMILY & COSMETIC DENTISTRY

Personal information

Thank you for selecting our dental team! We will always offer you the most up-to-date dental care available. And to help us meet your dental needs, please fill out these forms. Yes, we hate forms too, but this information is important. Thank you for your cooperation.

<input type="checkbox"/> Male	Patient's name	Your nickname	
<input type="checkbox"/> Female	Birth date	Social Security number	
<input type="checkbox"/> Single	Name of spouse	Patient's employer	
<input type="checkbox"/> Married	Patient's occupation		
	Patient's address		
	City	State	Zip
	Who may we thank for referring you to our office?		

Responsible party

Responsible party's name	Relation to patient		
Birth date	Social Security number		
Drivers license number			

I understand that neither Dr. Ratcliff nor his staff will treat anyone under the age of 18 without a parent/guardian signature.

Parent/guardian signature	Date
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How may we reach you?

Home phone number	Work phone number/extension		
Cell phone number	Pager number		
E-mail address			

Authorization and release

I authorize Dr. Ratcliff and his employees to release any information concerning my dental treatment, or my child's, to third-party payers and/or health practitioners. I also understand that Dr. Ratcliff's office is HIPPA compliant.

Patient's name	Parent/guardian's name		
Patient's signature (or parent/guardian of minor)			Date

If you have any questions, please give us a call at 817.274.7875. We're here to assist you.



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Medical Concerns

We're here to help you care for your teeth and to enhance your smile. In order to do so, we need even more information about you. The medications you are presently taking and the health problems you may have could affect how we develop your treatment plan. We know what a tedious process this is, so thank you in advance for your cooperation.

Name: _____

Birth date: _____

Medications

What medications are you taking—including "over the counter" products, such as aspirin or vitamins?

Are you allergic to:

- Penicillin Codeine
 Latex Metals
 Other (please list): _____

Heart Problems

What is your normal blood pressure? _____ / _____

Have you ever had any of the following conditions?

- Heart murmur Stroke
 Heart attack Rheumatic fever
 Angina Heart valve malfunction

Do you take antibiotics before dental appointments?

- Yes No

Periodontal disease and dental infections may increase the risk of stroke and coronary heart disease.

Do you have a pacemaker?

- Yes No

Have you ever had any other heart surgery?

- Yes No

Bleeding

Do you bleed easily? (*Aspirin can cause this.*)

- Yes No

Are you on Coumadin or other blood thinners?

- Yes No

Do you have Hepatitis?

- A B C D Jaundice

Diabetes

Do you have diabetes?

- Yes No

If yes, which type of diabetes?

- Type 1 Type 2

Breathing and Lungs

Do you have any of the following problems?

- Snoring (ask your spouse)
 Sinus problem Seasonal allergies
 Bronchitis Asthma

Is it hard to breathe normally through your nose?

- Yes No

Have your tonsils been removed?

- Yes No

Pregnancy

Are you pregnant?

- Yes No

Are you taking birth control pills?

- Yes No

Antibiotics can interfere with birth control pills and cause them not to work. Also, periodontal infections can increase the risk for low birth weights in newborns. This is very dangerous!

Cancer

Do you have cancer?

- Yes No

If so, what kind? _____

How are you being treated or how were you treated?

- Surgery Chemotherapy
 Radiation

Have you ever had cancer?

- Yes No

If so, when? _____ What kind? _____

General Questions

Do you smoke or use tobacco products?

- Yes No

How many packs per day? _____

Do you drink alcohol?

- Yes No

How many drinks per week? _____



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General Questions *(continued)*

Are you nervous? *(not just because you are in a dental office)*

Yes No

Do you have a mental health disorder?

Yes No

What is it? _____

Do you have to go to the bathroom often?

Yes No

Do you get dizzy often or if you stand up too fast?

Yes No

Do you know if you grind or clench your teeth?

Yes No

Do you get frequent headaches or earaches?

Yes No

Does your jaw joint click or pop?

Yes No

Is it painful?

Yes No

Do you have problems with previous dental work breaking?

Yes No

Do you feel bad if you skip lunch?

Yes No

Nerves, Bones and Muscles

Do you have any artificial or joint replacements?

Yes No

If yes, please describe:

Do you have back problems?

Yes No

Can you lie in a dental chair comfortably?

Yes No

Do you have a neuromuscular disorder?

Yes No

What is it? _____

Immune System

Lupus Organ transplant HIV

AIDS ARC

Physicians, Physical Therapists and Chiropractors

Please list everyone who is treating you at this time.

Name: _____

Phone: _____

Treatment: _____

Name: _____

Phone: _____

Treatment: _____

Name: _____

Phone: _____

Treatment: _____

Is there anything else you feel we need to know about the systems of your body?

The information I have just supplied is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and be used for the development of my treatment plan. I give my permission to Dr. Ratcliff or his staff to use any photos of my treatment for lecturing or educational purposes. I also understand that Dr. Ratcliff's office is HIPPA compliant.

Signature: _____

Date: _____



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Dental insurance

We know how wonderful it is to have the peace of mind of having dental insurance coverage and how important it is to receive the maximum insurance benefit you may qualify for. As a courtesy, we process the necessary claim forms in our office and directly submit the required documentation to insurance carriers to initiate the claim process. We are pleased that you have dental insurance to help supplement the cost of your dental care and are here to help you maximize your dental benefits. This includes checking benefits and eligibility and processing insurance claim forms. While we accept an assignment of benefit payments from most insurance companies, you will still be responsible for the total treatment fee. You will be responsible for the estimated portion of the treatment fee that your insurance coverage does not cover at the first scheduled treatment appointment. If we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of all outstanding fees. Please be aware, the information collected is directly from your insurance company and is a summary of benefits. Any estimate given from this information should be considered as an estimate. To help us achieve the highest level of benefits to which you are entitled, please fill in the following information:

Patient's legal name _____

Primary dental insurance company

Insurance company's phone number _____ Group number _____

Subscriber's legal name _____ Subscriber's social Security number _____

Subscriber's birth date _____ Relationship to patient _____

Drivers license number _____ State _____

Secondary insurance company

Insurance company's phone number _____ Group number _____

Subscriber's legal name _____ Subscriber's social Security number _____

Subscriber's birth date _____ Relationship to patient _____

Drivers license number _____ State _____

To ensure your satisfaction and to expedite insurance documents, this office sends e-claims which are HIPPA compliant. To better understand dental insurance and how it works, feel free to ask our qualified staff.

Signature _____ Date _____

If you have any questions, please give us a call at 817.274.7875. We're here to assist you.