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.

☐ Male
☐ Female
☐ Single
☐ Married

Patient's name _____ Your nickname _____

Birth date _____ Social Security number _____

Name of spouse _____ Patient's employer _____

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 _____

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

> SUBMIT form by email > PRINT form

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