

REGISTRATION INFORMATION

Name _____ Preferred name _____
Last Name First Name MI

Address _____ City _____ State _____ Zip _____

Soc. Sec.# _____ - _____ - _____ Drivers Lic.# _____

Birthdate _____ Age _____ Single _____ Married _____ Widowed _____ Divorced _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____

Occupation _____ Employer _____

Business Address _____

Are you a full time student? YES NO Which school? _____

Hobbies/Interests _____

Spouse's name _____ Spouse SS# _____ - _____ - _____

Occupation of spouse _____ Employer _____

Phone (work) _____ Spouse birthdate _____

Whom may we thank for referring you? _____

Emergency Contact Information

Name _____ Home Phone _____

Work Phone _____ Cell phone _____

Must complete if under 18 or full time student/Responsible Party Information Required

Father's Name _____ SS# _____ - _____ - _____

Father's Address _____

Father's Phone (home) _____ (work) _____

(cell) _____

Father's Employer _____

Mother's Name _____ SS# _____ - _____ - _____

Mother's Address _____

Mother's Phone (home) _____ (work) _____

(cell) _____

Mother's Employer _____

Dental History

Are you in discomfort today? If yes, explain. _____

Former dentist _____ Date of last dental care/x-rays _____

Place Y for yes or N for no in the blank if you have/have not had the following:

_____ Bad breath	_____ Food collection between teeth	_____ Periodontal treatment	_____ Sensitivity to sweets
_____ Bleeding gums	_____ Grinding or clenching teeth	_____ Sensitivity to cold	_____ Sensitivity to biting
_____ Clicking/popping jaw	_____ Loose teeth or broken fillings	_____ Sensitivity to hot	_____ Sores/growths in mouth

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? YES NO

Medical History

General Doctor's Name _____ Phone _____

Address _____ Date of last visit _____

Have you had any serious illnesses, operations, or had a hospital stay? _____ If yes, describe _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Women: Are you pregnant? _____ Nursing? _____ Taking birth control of any form? _____

Place Y for yes or N for no if you have ever had in the past or currently have any of the following:

_____ Aids	_____ Cough, persistant	_____ HIV positive	_____ Shingles
_____ Anaphylaxis	_____ Cough up blood	_____ Jaw pain	_____ Shortness of breath
_____ Anemia	_____ Diabetes	_____ Kidney disease	_____ Skin rash
_____ Arthritis, Rheumatism	_____ Epilepsy	_____ Liver disease	_____ Spina bifida
_____ Artificial heart valves	_____ Fainting	_____ Material Allergi	_____ Stroke
_____ Artificial joints	_____ Food allergies	(latex, wool, metal, chemicals)	_____ Surgical implant
_____ Asthma	_____ Glaucoma	_____ Mitral valve prolapse	_____ Swelling of feet/ankles
_____ Atopic (allergy prone)	_____ Headaches	_____ Nervous problems	_____ Thyroid disease
_____ Back problems	_____ Heart murmur	_____ Pacemaker/Heart surgery	_____ Tobacco habit
_____ Blood disease	_____ Heart problems	_____ Psychiatric care	_____ Tonsillitis
_____ Cancer	_____ High cholesterol	_____ Rapid weight gain or loss	_____ Tuberculosis
_____ Chemical dependency	_____ Hemophelia/abnormal	_____ Radiation treatment	_____ Ulcer/colitis
_____ Chemotherapy	bleeding	_____ Respiratory disease	_____ Venereal disease
_____ Circulatory problems	_____ Herpes	_____ Rheumatic fever	_____ Cold sores
_____ Cortisone treatments	_____ Hepatitis	_____ Scarlet fever	_____ High blood pressure

Are you currently taking or have taken in the past the following medications? Circle any that apply

Fosamax Phen-Phen Aredia Zometa

List medications you are currently taking (*including vitamins/herbal supplements*): _____

List drug allergies, if any: _____

AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist and staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I understand that I am financially responsible for all charges whether or not reimbursed by my insurance.

Signature _____ Date _____

Financial Policy

Thank you for choosing Ritchie Dental Group as your dental health care provider. We are committed to providing quality dental care and making your dental treatment pleasant and successful. Please understand that payment for treatment and services rendered is part of your treatment. The following policy has kept dental care costs down for our patients by eliminating the costly administrative expenses associated with billing procedures.

We accept the following methods of payment:

- ◆ Cash
- ◆ Checks
- ◆ Visa, Mastercard, Discover, American Express
- ◆ Care Credit and Unicorn (offer very affordable monthly payment plans)

Your payment for services will be due at the time treatment is rendered. We will then provide you with the necessary forms for you to simply drop in the mail for direct reimbursement to you by your insurance company.

Please note: Most insurance companies will not cover 100% of all of your dental expenses. Some treatment provided may not be considered reasonable or necessary under your particular plan and labeled “non-covered” or “plan exclusion”. The level of coverage of any dental plan is directly related to the level of payment made to the plan by the policy holder’s employer.

Thank you for your understanding of our Financial Policy. Please let us know if you have questions or concerns.

I have read and agree to honor this Financial Policy.

X _____
Signature of Patient or Responsible Party

Date _____

Printed Name

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we provide you with any opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, postcards, and/or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request copies, we will charge you \$0.25 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by e-mail, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with the address to file your complaint.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

Print name _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Mendy Ritchie, D.D.S.
Telephone: 830-693-8833
Fax: 830-693-1748
E-mail: ritchiedentalgroup@yahoo.com
Address: 1000 Marble Heights Drive Marble Falls, TX 78654

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____