

**Ritchie Dental Group, P.A.**  
1000 Marble Heights Dr. ~ Marble Falls, TX 78654 ~ 830-693-8833  
[www.ritchiedentalgroup.com](http://www.ritchiedentalgroup.com) ~ [info@ritchiedentalgroup.com](mailto:info@ritchiedentalgroup.com)

**REGISTRATION INFORMATION**

**Whom may we thank for referring you?** \_\_\_\_\_

**Name** \_\_\_\_\_ Preferred name \_\_\_\_\_  
Last Name First Name MI

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Soc. Sec. # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ **E-mail** \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Are you a full time student? YES NO Which School? \_\_\_\_\_

Hobbies/Interests \_\_\_\_\_

Single Married Widowed Divorced Spouse's name \_\_\_\_\_

**Emergency Contact Information (other than your spouse)**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

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Please answer the following questions as completely and accurately as you can. Also, please be as detailed as possible providing additional information you think is important. If you have any questions about this form or your upcoming appointment, contact our office for assistance.

Please circle YES or NO. If YES please explain on the line provided

**FOR WOMEN**

1. YES NO Are you pregnant? Expected delivery date? \_\_\_\_\_
2. YES NO Do you have a history of miscarriages? When? \_\_\_\_\_
2. YES NO Are you taking any form of birth control? What kind? \_\_\_\_\_

**Medical History:**

4. YES NO Do you have a current medical problem? \_\_\_\_\_
5. YES NO Do you have any heart problems? What kind? \_\_\_\_\_
6. YES NO Do you have: High/Low Blood Pressure? Is it controlled? Yes/No
7. YES NO Have you had pain in your chest or shortness of breath? \_\_\_\_\_
8. YES NO Has your physician ever told you that you are anemic? \_\_\_\_\_
9. YES NO Have you ever had a stroke? When? \_\_\_\_\_
10. YES NO Have you ever had epilepsy? \_\_\_\_\_
11. YES NO Do you have diabetes? Is it controlled? \_\_\_\_\_ What is your Hib1c#? \_\_\_\_\_
12. YES NO Do you feel like your sense of balance has changed? \_\_\_\_\_
13. YES NO Do you have headaches? How often? Where? \_\_\_\_\_
14. YES NO Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? \_\_\_\_\_
15. YES NO Have you been advised NOT to take any medication? What? \_\_\_\_\_

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- 16. YES NO Do you have asthma or hay fever? How is it controlled? \_\_\_\_\_
- 17. YES NO Have you ever had glaucoma? When? \_\_\_\_\_
- 18. YES NO Have you ever had hepatitis? When? \_\_\_\_\_
- 19. YES NO Have you ever had a tumor or cancer? What kind? \_\_\_\_\_  
How was it treated and where? \_\_\_\_\_
- 20. YES NO Have you ever had any major surgeries? What kind? \_\_\_\_\_
- 21. YES NO Have you ever been injured in an accident? When? \_\_\_\_\_
- 22. YES NO Is your diet medically supervised? For what purpose? \_\_\_\_\_
- 23. YES NO Do you have difficulty swallowing? \_\_\_\_\_
- 24. YES NO Do you have a feeling of something stuck in your throat? \_\_\_\_\_
- 25. YES NO Do you ever have any facial pain or pressure? Where? \_\_\_\_\_
- 26. YES NO Are you aware of stiff neck muscles? How often? \_\_\_\_\_
- 27. YES NO Do you have back pain? Where? \_\_\_\_\_
- 28. YES NO Do you ears ring, buzz, or hiss? How often? \_\_\_\_\_
- 29. YES NO Do you have emotional or anxiety/nervous problems? \_\_\_\_\_
- 30. YES NO Do you use tobacco? How long using? How many a day? \_\_\_\_\_

Please list any serious illnesses, hospitalizations or accidents: (if additional, please use back of page)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

Please list ALL medication and the dosage you are currently taking:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
- 5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_

Please list any allergies to any medications:

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

Other allergies (Materials, Epinephrine, Etc.)

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**DENTAL HISTORY:**

- 31. \*\*\*\*\* When was your last dental visit? \_\_\_\_\_
- 32. YES NO Have you been told that you have periodontal (gum) disease? \_\_\_\_\_
- 33. YES NO Do you have any existing problems with your teeth? Describe \_\_\_\_\_
- 34. YES NO Is any dental treatment planned? Describe \_\_\_\_\_
- 35. YES NO Do you bite your nails? \_\_\_\_\_
- 36. YES NO Have you ever had oral surgery? \_\_\_\_\_
- 37. YES NO Have you lost any teeth? How many? From what cause? \_\_\_\_\_
- 38. YES NO Have those teeth been replaced? When? \_\_\_\_\_
- 39. YES NO Have you ever had orthodontic treatment? When? \_\_\_\_\_
- 40. YES NO Have you ever had extensive dental treatment? When? \_\_\_\_\_
- 41. YES NO Is any part of your mouth sensitive to temperature, pressure, food, or drink?  
Where? \_\_\_\_\_
- 42. YES NO Do you wear dentures or partial dentures? Are they comfortable? \_\_\_\_\_

**TMJ HISTORY**

- 43. YES NO Do you ever have a burning or painful sensation in your mouth? \_\_\_\_\_
- 44. YES NO Do you hear popping, clicking, or grinding noises when you open or close? \_\_\_\_\_

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- 45. YES NO Do you ever waken of an awareness of your teeth or jaws? \_\_\_\_\_
- 46. YES NO Are you aware of clenching during the day time? How often? \_\_\_\_\_
- 47. YES NO Have you ever been told you grind your teeth during sleep? \_\_\_\_\_
- 48. YES NO Do you have trouble opening your mouth widely? \_\_\_\_\_
- 49. YES NO Does your jaw ever lock opened or closed? How often? \_\_\_\_\_
- 50. YES NO Do you feel your bite is different, unstable or uncomfortable? \_\_\_\_\_
- 51. YES NO What professional advice or treatments have you had regarding your TMJ, headaches or pain conditions/problems? \_\_\_\_\_
- 52. YES NO If you've sought treatment for a TMJ problem, did it help? \_\_\_\_\_
- 53. YES NO Do you have or have had any pain in any of the following areas? (circle)  
Jaw Ear Face Neck Teeth Head Other \_\_\_\_\_
- 54. YES NO Do your jaw problems affect your ability to chew? \_\_\_\_\_
- 55. YES NO Has your diet changed due to your jaw problems? Describe \_\_\_\_\_
- 56. YES NO Do your joint noises affect others while eating? \_\_\_\_\_

*As dentists we are often the first person to see changes in craniofacial anatomy leading to sleep disorders. Please take the time to fill out this important portion of your medical history.*

**SLEEP, SNORING, AND APNEA HISTORY**

- 57. YES NO Do you become easily fatigued? At what time of day? \_\_\_\_\_
- 58. YES NO Do you have problems with insomnia? \_\_\_\_\_
- 59. YES NO Do you sleep well? How long? \_\_\_\_\_
- 60. YES NO Do you dream? How often? \_\_\_\_\_
- 61. YES NO Do you have trouble falling asleep or staying asleep? Which \_\_\_\_\_
- 62. YES NO Do you snore or have you been told you do? \_\_\_\_\_
- 63. YES NO Do you wake up with a headache? \_\_\_\_\_
- 64. YES NO Have you had chronic sleepiness, fatigue, or weariness that you can't explain? \_\_\_\_\_
- 65. YES NO Do you often fall asleep reading or watching television? \_\_\_\_\_
- 66. YES NO Have you fallen asleep during the day against your will? \_\_\_\_\_
- 67. YES NO Have you had to pull off of the road while driving due to sleepiness? \_\_\_\_\_
- 68. YES NO Have you been more irritable or short tempered? \_\_\_\_\_
- 69. YES NO Have you felt that your memory/intellect is impaired? \_\_\_\_\_
- 70. YES NO Have you been told that you stop breathing while asleep? \_\_\_\_\_
- 71. \*\*\*\*\* About how many times per night do you wake up? \_\_\_\_\_
- 72. \*\*\*\*\* What time do you normally go to bed? \_\_\_\_\_ Wake up in the morning? \_\_\_\_\_
- 73. \*\*\*\*\* Of the hours that you are in bed, about how many hours are you asleep? \_\_\_\_\_
- 74. \*\*\*\*\* Would you rate the quality of your sleep as (circle) Good Fair Poor
- 75. YES NO Do you have difficulty breathing through your nose? \_\_\_\_\_
- 76. \*\*\*\*\* Present body weight: \_\_\_\_\_ lbs. Height \_\_\_\_\_ ft. \_\_\_\_\_ inches
- 77. YES NO Have you been diagnosed or treated for a sleep disorder? When \_\_\_\_\_
- 78. YES NO Have any immediate family members been diagnosed or treated for a sleep disorder? \_\_\_\_\_
- 79. YES NO Have you ever had an evaluation at a sleep center?  
Sleep Center Name: \_\_\_\_\_  
Location: \_\_\_\_\_  
Sleep Study Date: \_\_\_\_\_

80. What professional advice or treatment have you received about your snoring or sleep apnea?  
\_\_\_\_\_  
\_\_\_\_\_

81. If you sought treatment for a sleep disorder, did it help? \_\_\_\_\_  
\_\_\_\_\_

*I certify that the information about my medical history is correct to the best of my knowledge.*

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## **Oral Cancer Facts**

- An estimated 35,720 adults (25,240 men and 10,480 women) in the United States will be diagnosed with oral and oropharyngeal cancer.
- Over 40% of those diagnosed will die within five years - National Cancer Institute.
- The high mortality rate associated with oral cancer is due to late stage diagnosis.
- This is the third year in a row in which there has been an increase in the rate of occurrence.
- The death rate in the United States is higher than that of cancers which we hear about routinely such as breast, cervical, Hodgkin's, prostate, liver, testes, kidney, thyroid and colon.
- The incidence rate for oral cancer is 3 TIMES GREATER than cervical cancer in the US.
- Exposure to the HPV-16 virus (human papilloma virus) is the fastest growing risk factor for oral cancer.
- The mortality rate associated with oral cancer has not improved significantly in the last 40 years.
- 90% of oral cancer occurs in patients 45 years or older, which encompasses all 84 million Baby Boomers.
- An estimated 7,550 oral cancer patients died in 2007 (5180 men 2370 women).
- Rates of oral and oropharyngeal cancer are more than twice as high in men then women. Cancer of the oral cavity ranks as the ninth most common cancer among men.
- Women in their 40's now make up the fastest growing segment of the US population to be diagnosed.
- 90% of oral cancers are "Squamous Cell Carcinomas".
- One person dies from oral cancer every hour.
- 25% of oral cancers occur in people who don't smoke and have not other risk factors.

This is why our office recommends a potentially life saving screening called Identafi 3000. Oral cancer screenings are recommended annually. When oral cancer is found early, treatment is less invasive and outcomes far better.

By signing this form you acknowledge that you have reviewed the above information.

Signature \_\_\_\_\_

Date \_\_\_\_\_

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## 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:

- Φ Cash
- Φ Checks
- Φ Visa, MasterCard, Discover, American Express
- Φ Care Credit and American Health Care Lending

\*\*\*\*\*

***We also offer very affordable monthly payment plans to help keep your dental care within your monthly budget. Plans are provided through American Healthcare Lending, and Care Credit. We will be happy to assist you in exploring different options that will help you move forward with treatment in a way that is comfortable for you and your budget.***

\*\*\*\*\*

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.

We view our appointment times as a commitment that we will be here to serve you and you will be present for that appointment. Our practice requires a 48 hour notice for appointment changes. Without a notice, we cannot give that appointment opportunity to someone else in need of treatment. Therefore, missed appointments without 48 hour notice will result in a broken appointment fee of \$85.00 and you will be billed accordingly.

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 \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Printed Name

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## **CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

### **SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

### **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.

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](mailto: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: \_\_\_\_\_

## **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 \_\_\_\_\_

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