RITCHIE DENTAL GROUP, PA
PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name:	Sex: M / F	Select One of the Following: Single Married Separated Widowed	
DOB:	Age:	SSN:	
Mailing Address:	City:	State:	Zip Code:
Email:	Home #:	Cell #:	
Employer Name & Address:		Work #:	
Occupation:	Name of Spouse:	Spouse's Cell:	

DENTAL INSURANCE INFORMATION

Insurance Name:	Member ID #:	Group #:
Policy Holder's Information: Name:	DOB:	SSN:
Name & Address of Policy Holder's Employer:		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Address:
Phone #:	Relationship to Patient:

OTHER INFORMATION

How did you hear about our office?
What motivated you to make this appointment?

DENTAL HISTORY

Please check any of the following that apply to you:

- ☐ Sensitivity (Hot, Cold, Sweet)
  Where?
  UR UL LR LL
- ☐ Headaches, Ear Aches, or Neck Pain
- ☐ Jaw Joint Pain
- ☐ Mouth Ulcers/Cold Sores
- ☐ Broken Teeth or Fillings
- ☐ Grinding or Clenching Teeth
- ☐ Bleeding, Swollen, Irritated Gums
- ☐ Loose, Tipped, or Shifting Teeth
- ☐ Bad Breath

Do you have OR have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Gum Treatments

Previous Dentist:_____
City, St:_____
Phone#:_____
Why did you leave?_____

If you could whiten your teeth for a cost anyone could afford, would you do it?
Yes No

Do you smoke or use chewing tobacco?
Yes No

If Yes:
How long? _____
How much? _____

If I could change my smile, I would:

- ☐ make my teeth whiter
- ☐ make my teeth straighter
- ☐ close spaces
- ☐ replace metal fillings with tooth colored fillings
- ☐ repair chipped teeth
- ☐ replace missing teeth
- ☐ replace crowns that don't match
- ☐ have a smile makeover

What is the date of your last:
Cleaning - _____
Screening for Oral Cancer - _____
Complete Set of X-Rays - _____

What is most important, to you, about your future smile & dental health?
_____

What is most important, to you, about your dental visit today?
_____

On a scale of 1-10, with 10 being the highest:
How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Are you currently under a physician's care? ☐Yes ☐No For what? _____
Physician: _____ Phone#: _____

Please check any of the following that apply to you:

☐Anemia	☐Depression	☐High Blood Pressure	☐Rheumatoid Arthritis
☐Anxiety	☐Diabetes	☐High Cholesterol	☐Ringing/Buzzing of Ears
☐Aortic Stenosis	☐Difficulty Swallowing	☐HIV/AIDS	☐Shingles
☐Artificial Joints	☐Endocarditis	☐Kidney Disease	☐Sleep Apnea
☐Artificial Valves	☐Epilepsy/Seizures	☐Liver Disease	☐Snoring
☐Asthma	☐Fainting/Dizziness	☐Mitral Valve Prolapse	☐Stomach Ulcer/ U.C.
☐Back Problems	☐Glaucoma	☐Migraines	☐Stroke
☐Blood Disease	☐Headaches	☐Osteoporosis	☐Surgical Implant
☐Blood Thinners	☐Heart Disease	☐Osteopenia	☐Tachycardia
☐Cancer	☐Hemophelia	☐Pacemaker	☐Thyroid Disease
☐Chemotherapy	☐Hepatitis	☐Radiation Treatment	☐Tobacco Habit
☐Circulatory Problems	☐Herpes/Cold Sores	☐Respiratory Problems	☐Tuberculosis

Are you allergic to any of the following?

☐Aspirin	☐Erythromycin	☐Penicillin
☐Codeine	☐Latex	☐Sulfa
☐Epinephrine	☐Nitrous Oxide	☐Other _____

For Women Only:
☐Birth Control
☐Breast Feeding
☐Pregnant ...How far along?_____

Please list any major surgeries you have had:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

What medications are you currently taking?

_____
_____
_____
_____

Ritchie Dental Group, P.A.

Greg A. Ritchie, D.D.S. • Mendy D. Ritchie, D.D.S.

FINANCIAL GUIDELINES

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

*******Payment is due at the time that the service is provided.*******

Our office accepts ***CASH, CHECKS, MONEY ORDERS, ALL MAJOR CREDIT CARDS,*** and ***CARE CREDIT***. Outside financing is available upon request and approval.

Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service or legal assistance; you will be responsible for any collection and/or legal charges incurred.

For our patients with Dental Insurance:

As a courtesy to you, we will help you process all your dental insurance claims. We must emphasize that, as your dental healthcare provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Ritchie Dental Group is not a party to that contract.

- We ask that your estimated patient portion be paid on or before the date of service.
- We will cooperate fully with the regulations and requests of your insurance company, to assist in the claim being paid. We will not, however, enter into a dispute with your insurance company over any claim.
- All charges you incur are your responsibility, regardless of your insurance benefits.
- Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We will provide you with an insurance estimate for any treatment recommended, and we will do all we can to ensure the estimate is as accurate as possible. Please understand that this is not a guarantee that your insurance will pay exactly what was estimated. Your insurance company and your plan benefits will ultimately determine the amount paid.
- Insurance payments are ordinarily received within 30 to 60 days, from the time of filing. If your insurance company has not made payment within 60 days, the balance becomes your responsibility, regardless of any expected insurance payment.
- We ask that you sign this form and any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to Ritchie Dental Group.

We thank you for the opportunity to serve your dental healthcare needs and welcome any questions you may have concerning your care, or our financial policy.

I, _____, have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

_____ _____

Signature Date

Bus: 830-693-8833 • Fax: 830-693-1748 • 1000 Marble Heights Dr. • Marble Falls, TX 78654
www.ritchiedentalgroup.com

Ritchie Dental Group, P.A.
1000 Marble Heights Dr. ~ Marble Falls, TX 78654 ~ 830-693-8833
www.ritchiedentalgroup.com ~ info@ritchiedentalgroup.com

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:

Mendy Ritchie, D.D.S.
Telephone: 830-693-8833
Fax: 830-693-1748
E-mail: info@ritchiedentalgroup.com
Address: 1000 Marble Heights Dr, Marble Falls, TX 78+54

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of you revocation submitted to the contact person listed above. Please understand that revocation of the 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 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 _____

HIPAA 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 Dental Practice Covered by this Notice

This Notice describes the privacy practice of Ritchie Dental Group, PA. "We" and "our" means the Dental Practice. "You and "your" means our patient.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you and your child, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing dental care services to you, to pay your dental care bills, to support the operation of the dental practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI may be provided to a physician or dentist to whom you have been referred to ensure that the physician or dentist has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your dental care services. For example, obtaining approval for dental care may require that your relevant PHI be disclosed to the dental plan to obtain approval for the necessary services.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities of our dental practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of dental students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to dental school students that see patients at our office. In addition, we may use a sign-in sheet or computer at the registration desk where you will be asked to sign your name and indicate your dentist or hygienist. We may also call you by name in the waiting room when your dentist or hygienist is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may use email, text messaging or fax to communicate with you. If you do not want electronic communications, you may request in writing to not receive electronic communications.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect: Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made Only with Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dental practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If your dentist believes it is in your best interest to permit use and disclosure of PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive a copy of confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. In response to this request, we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

As described in The Breach Notification Rule that is part of the HITECH Act of 2009, our office will notify all responsible parties of any breach of unsecured protected health information.

We reserve the right to change the terms of this notice and will inform you at your next dental appointment of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

How to Contact Us/Our Privacy Official
If you have any questions or would like further information about this Notice, you can either write to or call the Privacy Official for our Dental Practice.

Dental Practice Name:	Ritchie Dental Group, PA
Privacy Official for Dental Practice:	Mendy Ritchie, DDS
Dental Practice mailing address	1000 Marble Heights Dr. Marble Falls, TX 78654
Dental Practice email address	info@ritchiedentalgroup.com
Dental Practice phone number:	(830)693-8833