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R I G B Y D E N T A L

Welcome

It is a pleasure to serve you! Please fill out the front and back completely. The better we communicate, the better we can help you. If you have any questions, please ask.

PATIENT INFORMATION

NAME _____
PREFERRED NAME _____ MALE FEMALE
HOME # _____ WORK # _____
CELL # _____ EXT _____
BIRTHDATE ____/____/____ AGE _____
SS# _____-_____-_____
ADDRESS _____
STREET _____
CITY _____ STATE _____ ZIP _____
EMAIL ADDRESS _____
(for our use only)
 SINGLE MARRIED WIDOWED DIVORCED
EMPLOYER _____
OCCUPATION _____ HOW LONG THERE? _____
FAMILY MEMBERS SEEN BY US _____

RESPONSIBLE PARTY INFORMATION

NAME _____
PREFERRED NAME _____ MALE FEMALE
HOME # _____ WORK # _____
CELL # _____ EXT _____
BIRTHDATE ____/____/____ AGE _____
SS# _____-_____-_____
ADDRESS _____
STREET _____
CITY _____ STATE _____ ZIP _____
EMAIL ADDRESS _____
(for our use only)
 SINGLE MARRIED WIDOWED DIVORCED
EMPLOYER _____
OCCUPATION _____ HOW LONG THERE? _____
FAMILY MEMBERS SEEN BY US _____

IN THE EVENT OF EMERGENCY, IS THERE SOMEONE NOT LIVING WITH YOU THAT WE COULD CONTACT?

NAME _____ RELATIONSHIP _____ CELL # _____ HOME # _____
REFERRAL SOURCE : YELLOW PAGES INSURANCE MAILER/AD WALK IN INTERNET
 FRIEND/FAMILY _____ OTHER _____

PRIMARY DENTAL INSURANCE INFORMATION

INSURANCE NAME _____ POLICY HOLDER ID # _____
INSURANCE CLAIM ADDRESS _____
INSURANCE PHONE # (____) _____ GROUP # _____
POLICY HOLDER NAME _____ BIRTHDATE ____/____/____ SS# _____-_____-_____
EMPLOYER _____ RELATIONSHIP TO PATIENT _____

SECONDARY DENTAL INSURANCE INFORMATION

INSURANCE NAME _____ POLICY HOLDER ID # _____
INSURANCE CLAIM ADDRESS _____
INSURANCE PHONE # (____) _____ GROUP # _____
POLICY HOLDER NAME _____ BIRTHDATE ____/____/____ SS# _____-_____-_____
EMPLOYER _____ RELATIONSHIP TO PATIENT _____

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. A monthly service charge at a fixed rate of 18% per month* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding ninety (90) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination. In consideration for the professional services rendered to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission charged by the collection agency to whom a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary. I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matter related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member. This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void. I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care. I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. I agree to pay the remaining balance plus all collection/court costs and fees (a minimum of 33.3% of the balance) if a delinquent balance is placed with a collection agency or attorney.

There is a \$25.00 charge per hour for appointments missed without 24 hour notice.

SIGNATURE OF PATIENT OR GUARDIAN _____

Date _____

continued on Back →

DENTAL HEALTH

HAVE YOU COME TO THE OFFICE FOR PAIN RELIEF? YES NO IF YES, HOW LONG HAS IT HURT? _____
DOES IT HURT WITH? HOT COLD SWEETS CONSTANTLY
HOW LONG SINCE YOU'VE BEEN TO A DENTIST? _____ YEARS _____ MONTHS
WHEN WAS YOUR LAST SET OF FULL MOUTH X-RAYS? _____
ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES NO IF NOT, WHY? _____
HAVE YOU EVER HAD ANY INJURY TO YOUR FACE, JAW OR TEETH? YES NO IF YES, EXPLAIN? _____
HAVE YOU EVER HAD ANY ISSUES ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____
HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE? YES NO HOW LONG AGO? _____
ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH THE FOLLOWING?
 BAD BREATH LOOSE TEETH BROKEN FILLINGS
 BLEEDING OR TENDER GUMS CLENCH/GRINDING TEETH FOOD CAUGHT BETWEEN TEETH
 SORES OR GROWTH IN MOUTH CLICKING OR POPPING JAW

MEDICAL HISTORY

HOW WOULD YOU DESCRIBE YOUR GENERAL HEALTH? POOR FAIR GOOD EXCELLENT
ARE YOU NOW BEING TREATED OR HAVE YOU BEEN TREATED IN THE LAST YEAR BY A PHYSICIAN? YES NO EXPLAIN _____

NAME OF PHYSICIAN _____ PHONE # _____
NAME OF PREVIOUS DENTIST _____
ARE YOU TAKING ANY MEDICATION CURRENTLY? YES NO IF YES, LIST THEM BELOW? _____

HAVE YOU EVER HAD OR HAVE ANY OF THE FOLLOWING? YES NO IF YES, CHECK BELOW:
 ARTHRITIS, RHEUMATISM ARTIFICIAL HEART VALVES ARTIFICIAL JOINTS (HIP OR KNEE)
 ASTHMA BLOOD DISEASE CANCER
 CHEMOTHERAPY DIABETES EPILEPSY/FAINTING
 HEART MURMUR HEART PROBLEMS HEPATITIS
 HIGH BLOOD PRESSURE HIV/AIDS JAW PAIN
 KIDNEY DISEASE LIVER DISEASE MITRAL VALVE PROLAPSE
 PACEMAKER RHEUMATIC FEVER THYROID PROBLEMS
 TOBACCO HABIT TUBERCULOSIS OTHER _____

(WOMEN) ARE YOU PREGNANT? YES NO DUE DATE _____ NURSING? YES NO TAKING BIRTH CONTROL PILLS? YES NO

ALLERGIES

HAVE YOUR EVER HAD ANY UNUSUAL OR ALLERGIC REACTIONS TO ANY OF THE FOLLOWING? YES NO IF YES, CHECK BELOW:
 NO ALLERGIES LORTAB TETRACYCLINE
 PENICILLIN/AMOXICILLIN ERYTHROMYCIN ASPIRIN
 CEPHALEXIN LOCAL ANESTHETIC ACRYLIC
 CODEINE METALS (NICKEL OR GOLD) OTHER _____
 LATEX METALS
 EPINEPHRINE NON-STEROIDAL ANTI-INFLAM.

CONSENT TO PROCEED

I authorize Dr. Bradley S. Rigby and/or such associates or assistants as s/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and /or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation. I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions. I am aware Dr. Rigby does not use amalgam (mercury) fillings to restore teeth. I understand if my insurance does not cover composite fillings, I am responsible to pay the difference. After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required. I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal. I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-Fen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Date

NAME OF PATIENT (PLEASE PRINT)

SIGNATURE OF RESPONSIBLE PARTY

(For office use only)

Medical Updates

DATE	EXCEPTIONS	RESPONSIBLE PARTY SIGNATURE	REVIEWED BY
_____	_____	NONE _____	DR. _____
_____	_____	NONE _____	DR. _____