WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____
Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ Ext _____ Alt. Phone (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	Yes	No	Epilepsy	Yes	No	Respiratory Disease	Yes	No
Anemia	Yes	No	Fainting or dizziness	Yes	No	Rheumatic Fever	Yes	No
Arthritis, Rheumatism	Yes	No	Glaucoma	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No	Headaches	Yes	No	Shortness of Breath	Yes	No
Artificial Joints	Yes	No	Heart Murmur	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Heart Problems	Yes	No	Skin Rash	Yes	No
Back Problems	Yes	No	Hepatitis Type _____	Yes	No	Special Diet	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No	Herpes	Yes	No	Stroke	Yes	No
			High Blood Pressure	Yes	No	Swollen Feet or Ankles	Yes	No
Blood Disease	Yes	No	Jaundice	Yes	No	Swollen Neck Glands	Yes	No
Cancer	Yes	No	Jaw Pain	Yes	No	Thyroid Problems	Yes	No
Chemical Dependency	Yes	No	Kidney Disease	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Circulatory Problems	Yes	No	Low Blood Pressure	Yes	No	Tumor or growth on head or neck	Yes	No
Congenital Heart Lesions	Yes	No	Mitral Valve Prolapse	Yes	No			
Cortisone Treatments	Yes	No	Nervous Problems	Yes	No	Ulcer	Yes	No
Cough, persistent or bloody	Yes	No	Pacemaker	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Psychiatric Care	Yes	No	Weight Loss, unexplained	Yes	No
Emphysema	Yes	No	Radiation Treatment	Yes	No			

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No Due date_____ Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone (___) _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other _____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Financial Policy

This is an agreement between Cecil Riter DDS and the Patient/Guarantor named on this form.

1. *If you carry the following contracted insurance:*

   HDS, Delta Dental, HMSA, United Concordia, Metlife, Aetna or Cigna patients **pay for any out-of-pocket portions** at the time services are rendered. Unfortunately, most plans do not pay Hawaii State tax and will be due at the time services are rendered.

2. On extensive treatment (crowns, bridges or implants) we ask you **pay ALL or 50% your out-of-pocket portion** on the preparation date, and the balance on the completion date (Normally 2 weeks later).

Contracted Insurance: *We are obligated to follow our contract and the insurance company's requirements. If you have a co-pay or deductible, that payment is* made *at the time* of *service. It is the insurance company that makes the final determination* of *your eligibility. You agree to pay any portion* of *the charges not covered by insurance.*

3. *If you carry the following non-contracted insurance:*

   Guardian, GEHA, BCBS, Ameritas, HMAA, Humana, AARP, or United Health Care patients **pay the full amount** at the time services are rendered. We will request your insurance company send the reimbursement check directly to you.

Non-contracted Insurance: *Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it* is *the insurance company that makes the final determination* of *your eligibility. You agree to pay any portion* of *the charges not* covered *by insurance.*

4. **Missed appointment fee:** Patients who do not show up on time for an appointment, orcancel with less than 48 hours notice we will assess a $40 fee to your account.

5. **Past due accounts:** If your account becomes past due, we can take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. In case of suit, you agree the venue shall be in Honolulu County, Hawaii.

_____

Printed patient full name

_____ _____

Signature of responsible Party Acknowledgment **Date**