Ridge Road
Family Dentistry

Address : 5752 Ridge Rd, parma, oh 44129

All information is confidential and will remain with this office. The dental administration staff is available to help you complete any portion of this form. Full completion of the forms will allow us to provide you with the highest standard of dental care. Thank you for your co-operation.

REGISTRATION INFORMATION

Dr. / Mr. / Mrs. / Ms. / Miss:_____

Date of Birth:_____ Age:_____

ADDRESS:_____
(Street) (Apt/Unit#) (City) (Prov) (Postal Code)

Home Phone: ( )_____ E-Mail: _____

Bus. Phone: ( )_____ Ext_____ Employer:_____

Cell Number: ( )_____

Do you have Dental Insurance?_____ Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

Is there Secondary/Co- insurance? If yes, Name of policy holder?:_____

Employer of individual subscriber:_____ Date of Birth of policy holder: _____
M/ D/ Y

Name of insurance Company:_____

Group/Policy #_____ Certificate/ID#_____

Do you have or have had any of the following? Please indicate by circling:

- heart problems / surgery pacemaker
- chest pain
- excessive bleeding fainting / dizziness
- blood disorders
- high / low blood pressure anemia
- sinus problems
- asthma / emphysema lung / breathing problems surgery in hospital
- organ transplant /medical implant
- diabetes
- kidney problems
- hepatitis / liver problems rheumatic / scarlet fever epilepsy / seizures
- measles / mumps / chicken pox thyroid disease
- ulcers / stomach problems stroke / paralysis
- arthritis / gout
- circulation problems artificial joints (e.g. hip, knee)
- pregnancy (months?____)
- strep throat
- tonsillitis
- tuberculosis
- transmittable diseases venereal disease, herpes HIV / AIDS
- contagious diseases anxiety problems psychiatric problems steroid therapy
- cancer / tumors
- radiation or chemotherapy

Allergies:_____

Please indicate any other medical conditions that we have not mentioned above: _____

_____

Please indicate any PRESCRIPTION or NON-PRESCRIPTION medications, pills or drugs which you are taking: _____

Do you have FREQUENT, SEVERE headaches, earaches, ear/throat infections?_____

Do you have any other questions or concerns?_____

Any other family members patients at our office?(please list)_____

How did you hear about us? _____

Do you have a specific need? If yes, please describe: _____

How often do you see the dentist? _____

When was your last dental visit?_____What was done?_____

When was the last time you had any dental x-ray taken?_____

Do your gums ever bleed, are they swollen or painful?_____	YES	NO
Do you ever have jaw joint pain? _____	YES	NO
Do you ever clench or grind your teeth? _____	YES	NO
Are you aware of any swelling, sore spots or lump(s) in your mouth? _____	YES	NO
Have you ever had any traumatic injury to your face? _____	YES	NO
Have you ever noticed any loose teeth or have any of your teeth shifted?_____	YES	NO
Have you been advised to take antibiotics before a dental appointment? _____	YES	NO
Do you smoke? If so, how much? _____	YES	NO
Do any of your teeth hurt/ache (e.g. sensitive to sweet, cold, hot, pressure)?_____	YES	NO

Please describe: _____

Have you had any kind of oral surgery? _____	YES	NO

Doctor who performed oral surgery:_____ Phone ( )_____

Have you ever had Orthodontics (Braces)?_____	YES	NO

Doctor's Name:_____ Phone ( )_____ Date of last exam: _____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical - dental history. **Should there be any change in my health status in the future, I will advise this dental office.** I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another healthcare provider may be necessary, and I consent to the release of this information. I authorize release, to my insurance company/plan administrator, the information contained in claims electronically and for direct assignment to the dental office, if applicable. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services.

Financial Responsibility Agreement
By signing below, I acknowledge and agree to the following:

- I understand that, regardless of my insurance status, I am fully responsible for all balances and for all services provided.
- I understand that my insurance policy is a contract between me and my insurance company, and any remaining balance not covered by insurance is my responsibility.
- I understand that full payment, including co-payments and deductibles, is due at the time of service.

Please Note: A potential fee of $50 may be charged for any missed/rescheduled appointments without 2 full business day's notification.

X_____
(Signature) Patient ___ Parent___ Guardian___ (print name of guardian)

Date:_____ Reviewed by Treating Dentist: _____