Ritter & Ramsey, LLC

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PATIENT INFORMATION

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

If student, name of school

_____

_____

If student, check one:

☐ Full-Time Student ☐ Part-Time Student

Other Address/Up-North Address:

_____

_____

Referred By:

_____

_____

Emergency Contact, Relationship, and Telephone:

_____

_____

Employment Info

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Social Security # (numbers only, no dashes) _____

Primary Dental Insurance Information

Policy Holder Info:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Social Security #: _____

Insurance Phone #: _____

Secondary Dental Insurance Information

Policy Holder Info:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Social Security #: _____

Insurance Phone #: _____

MEDICAL HISTORY

Name of Physician

_____

_____

Physicians Phone # _____

Have you been treated by a physician or hospitalized for a serious condition? ◯ Yes ◯ No

For what condition?

_____

_____

_____

Currently taking any medications? ◯ Yes ◯ No

Please list medications taken:

_____

_____

_____

Do you pre-med for dental visits? (take antibiotic for condition 1 hour prior to appointment) ◯ Yes ◯ No

What medication? _____

Do you have or have you had any of the following conditions?

- ☐ .
- ☐ Artificial Joint
- ☐ Blood Disease
- ☐ Chemotherapy
- ☐ Coumadin
- ☐ Emphysema
- ☐ Growths
- ☐ Heart Disease
- ☐ HIV
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ Other
- ☐ Prolonged bleeding
- ☐ Rheumatic Fever
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Aspirin Allergy
- ☐ Blood Transfusions
- ☐ Chest Pain
- ☐ Damaged Heart Valves
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Iodine Allergy
- ☐ Kidney Stone
- ☐ MitralValve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric tx.
- ☐ Rheumatism
- ☐ Stroke
- ☐ Tumors
- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Serious Illness
- ☐ Sulfa Allergy
- ☐ Ulcers
- ☐ Arthritis
- ☐ Augmentin Allergy
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Dizziness/Fainting
- ☐ Glaucoma
- ☐ Heart Defect
- ☐ High Blood Pressure
- ☐ Kidney Dialysis
- ☐ Major Operations
- ☐ Organ Transplants
- ☐ Premed
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Thyroid Disease
- ☐ Venereal Disease

Notes:

_____

_____

Do you have any type of milk allergy? ◯ Yes ◯ No

Are you allergic to or have you reacted adversely to any medications?

_____

_____

Have you had any unfavorable experience with previous dental treatment? ◯ Yes ◯ No

Female Patients:

Are you pregnant? ◯ Yes ◯ No

If yes, what month? _____

Are you nursing? ◯ Yes ◯ No

To the best of my knowledge, the foregoing questions have been accurately answered. I, the underdesigned, being the patient or guardian of the above mentioned patient, consent to the administration of a local anesthetic in conjunction with dental treatment. I grant the right to release health information obtained from me, and information about my dental treatment to the third party payors and/or other health practitioners. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me. I also understand I am responsible for payment of services at the time they are rendered and for any unpaid balances in the the event of third party or insurance claims. We gladly accept cash, check or credit card. An updated and current insurance and credit card will be requested of you each time at check in. If you have any outstanding balance after your insurance claim has processed, your credit card will be charged for the outstanding amount and a receipt will be mailed to you. I understand that failure to pay any outstanding balances may result in additional fees if sent to collections.

Signature _____ **Date** _____

Response Date: _____