PARADISE RIDGE
DENTISTRY

SMILE EVALUATION

1. **What is your level of comfort when visiting the dentist?**

   No anxiety _____? Low anxiety? _____ High anxiety? _____

2. **Do you have any concerns about bad breath odor?**

   _____

3. **Are you pleased with the appearance of your teeth when you smile?**

   _____

4. **Are you pleased with the color of your teeth?**

   _____

5. **Are you pleased with the shape of your teeth?**

   _____

6. **Are there spaces between your teeth that you do not like?**

   _____

7. **Are your teeth chipped? _____ protruding? _____ hidden? _____ crowded? _____**

8. **Do you like the way your teeth fit together when you bite down?**

   _____

9. **Are there old fillings or dental treatment that you are not happy with?**

   _____

10. **If you could change anything about the appearance of your smile, what would you change?**

    _____

    _____

11. **Is there anything about the shape or alignment of your jaw that you are not happy with?**

    _____

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PARADISE RIDGE
DENTISTRY

PARADISE RIDGE DENTISTRY NEW PATIENT INFORMATION FORM

FIRST, MIDDLE & LAST NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOW DO YOU WISH TO BE CONTACTED. HOME PHONE _____WORK PHONE_____

CELL PHONE: _____ TEXT_____EMAIL_____

SS# _____-_____-_____ BIRTH DATE: _____/_____/_____ MARITAL STATUS S / M / D / W SEX: M / F

EMPLOYER NAME AND ADDRESS: _____

HOW DID YOU LEARN ABOUT US? ☐ ONLINE ☐ YELP ☐ MAILER ☐ RADIO OTHER _____

REFERRAL (PLEASE PROVIDE NAME OF WHO REFERRED YOU) _____

EMERGENCY CONTACT_____PHONE #_____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME AND ADDRESS: _____

RELATIONSHIP TO PATIENT: _____ SS#: _____/_____/_____ DOB: _____/_____/_____

EMPLOYER NAME AND ADDRESS FOR SUBSCRIBER: _____

INSURANCE COMPANY NAME, ADDRESS, PHONE NUMBER: _____

_____ GROUP #: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits of which I am entitled. I will not hold the dentist or any other member of his/her staff responsible for any errors or omissions that I may have made during the completion of this form.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of my services unless other financial arrangements have been made in advance. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by my insurance policy. I acknowledge that payment is due at the time of my services unless other financial arrangements have been made in advance. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/ child. I accept full financial responsibility for all charges not covered by my insurance policy. I understand that my insurance will be billed as a courtesy to me, the patients, and that any remaining balance will be my full responsibility regardless of my estimated benefits. I understand that there will be an additional $25.00 fee per patient to have the office analyze my account. In the event that account collections become necessary, the patient will be responsible for all collection costs including attorney fees of 35% of the pending balance.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

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DENTISTRY

PATIENT MEDICAL HISTORY

FIRST, MIDDLE & LAST NAME: _____ DATE: _____

PRIMARY CARE PHYSICIANS NAME, ADDRESS AND PHONE NUMBER: _____

_____

PHARMACY NAME: _____ PHONE NUMBER: _____

PLEASE MARK YES OR NO TO THE FOLLOWING

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Heart Attack	☐	☐	Ulcers
☐	☐	Alcohol Abuse	☐	☐	Heart Surgery	☐	☐	Venereal Disease
☐	☐	Allergies	☐	☐	Hemophilia	☐	☐	Yellow Jaundice
☐	☐	Anemia	☐	☐	Hepatitis A	☐	☐	Artificial Joints
☐	☐	Angina Pectoris	☐	☐	Hepatitis B	☐	☐	Ever taken Fen-Phen?
☐	☐	Arthritis	☐	☐	Hepatitis C	**ALLERGIES**		
☐	☐	Artificial Heart Valve	☐	☐	High Blood Pressure	☐	☐	Aspirin
☐	☐	Asthma	☐	☐	HIV+, AIDS	☐	☐	Codeine
☐	☐	Blood Transfusion	☐	☐	Kidney Problems	☐	☐	Dental Anesthetics
☐	☐	Cancer, Cancer Treatment	☐	☐	Liver Disease	☐	☐	Erythromycin
☐	☐	Chronic Fatigue Syndrome	☐	☐	Low Blood Pressure	☐	☐	Jewelry
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse	☐	☐	Latex
☐	☐	Cosmetic Surgery	☐	☐	Monoucleosis	☐	☐	Metals
☐	☐	Diabetes	☐	☐	Pace Maker	☐	☐	Penicillin
☐	☐	Difficulty Breathing	☐	☐	Pneumocystitis	☐	☐	Sulfa
☐	☐	Drug Abuse	☐	☐	Radiation Therapy	☐	☐	Tetracycline
☐	☐	Emphysema	☐	☐	Rheumatic Fever	☐	☐	OTHER
☐	☐	Epilepsy	☐	☐	Sickle Cell Disease	_____		
☐	☐	Fainting Spells	☐	☐	Sinus Problems	_____		
☐	☐	Fever Blisters	☐	☐	Stroke	_____		
☐	☐	Fibromyalgia	☐	☐	Thyroid Problems	_____		
☐	☐	Frequent Headaches	☐	☐	Tuberculosis	_____		
☐	☐	Glaucoma				_____		
☐	☐	Hay Fever						

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

DOCTOR'S SIGNATURE: _____ DATE: _____

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MEDICAL CONTINUATION FORM

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

_____

_____

_____

_____

_____

_____

IS THERE ANY DISEASE, CONDITION OR PROBLEM THAT YOU THINK THIS OFFICE SHOULD BE AWARE OF THAT WAS NOT LISTED ABOVE? IF YES, PLEASE DESRIBE: _____

_____

_____

_____

_____

_____

_____

NOTES: (FOR OFFICE USE ONLY) _____

_____

_____

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_____

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Dear Friends,

Trying to accommodate every patient's individual needs and work schedule can be difficult. We work very diligently to stay on schedule to minimize your wait time in our office.

A scheduled appointment time is a commitment we have to one another and it has to be reserved especially for you, our valued patient. When appointments are missed or canceled, that valuable time is lost.

If you find that you are unable to keep your reserved appointment, ample notice will allow us to schedule another patient in need of treatment in your place.

It is our office policy to apply either of the two charges to your account with less than 48 hours' notice for a change of commitment:

- If your appointment is with the Hygienist a $45.00 charge will apply.
- If you are scheduled with the Doctor and/ or for Treatment, then a $90.00 charge will be applied.

Please be aware that we understand unforeseen circumstances do occur and we can appreciate that emergencies do happen. All charges are subject to review by the owner of Paradise Ridge Dentistry and/or the office manager.

If you have any questions regarding this or any other office policy or procedure, we are always more than happy to discuss them with you.

Thank you in advance for your continued cooperation and understanding.

Sincerely,
Paradise Ridge Dentistry

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The U.S. Congress mandated the Health Insurance Portability and Accountability Act in 1996. The law became effective April 14, 2003. It was designed to protect patient confidentiality of medical information that has in the past been passed between health insurance plans, banking establishments and employers. The information was and could have been used at the detriment of and to the patient/client.

As a covered entity by definitions of the law, we must abide by the laws set forth by this act. Here, at Paradise Ridge Dentistry, we look at these changes as a mechanism to protect the consumer's health information. It is our intention to abide by the law to our utmost ability. We do not release any personal information to outside sources unless you have directly given us your authorized permission to do so.

I, _____ have received and or read a copy of this office's notice of privacy practices. I fully understand that this office will only release information that is pertinent to the processing of my insurance claims. If I am not using insurance than there will be no release of my records or information unless to a referring specialist to facilitate my scheduling.

I am fully aware that electronic filing to my insurance company can be done now or will be done in the future for me by Paradise Ridge Dentistry. I am aware that I have the right to revoke, file a complaint, request information regarding such a complaint or to change my information that is truthful concerning my health history. I am in consent with this office and their practices safeguarding my private health information according to the HIPAA rules and regulations.

PATIENT/GUARDIAN NAME: (PRINT) _____

PATIENT/GUARDIAN NAME: (SIGN) _____

DATE: _____

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Oral ID Cancer Screenings

OralID™
Shine Light. Save Lives.

Oral Cancer is on the rise in the US, it is predicted this year that over 34,000 people in the United States will be diagnosed with oral cancer. At Paradise Ridge Dentistry, we care about your health. Although we provide oral cancer screening as part of your comprehensive dental exam this is not always enough. For this reason, we have chosen a more advanced method of prevention. OralID Florescence Technology, an award winning oral cancer screening device emits blue light to identify abnormal lesions, including cancer and pre-cancer in your mouth that could be missed by the naked eye under traditional white light. When the blue light shines on normal tissue, it appears green. However, malignant lesions show up as dark, which makes it much easier to detect unhealthy tissue.

Having an OralID cancer screening annually is safe and simple and can help save your life. The cost of the oral cancer screening is $35.00. This will be billed to your insurance, but we need to collect upfront in the event that it's not covered by insurance. Please indicate below if you would like the oral cancer screening performed during your appointment today.

_____ Yes, I would like an OralID screening during my appointment.

_____ No, I would not like an OralID screening during my appointment.

Signature _____ Date _____

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