Ross Dental Group
Something to Smile About

Ross Dental Group
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Fairfield, OH 45014
513-738-2606

TO INCREASE THE LEGIBILITY OF SCANNED DOCUMENTS, PLEASE PRESS FIRMLY, WRITE CLEARLY & USE ONLY BLACK OR DARK BLUE

PATIENT REGISTRATION / RESPONSIBLE PARTY

Today's Date _____

Patient's **LEGAL** First Name _____ Middle _____ Last Name_____

Preferred Name / Nickname _____ OH DL Lic #'s are 2 letters & 6 numbers

Date of Birth _____ SSN* _____ Driver Lic.* #_____

** SSN's are used by many insurance companies as your ID #. Your driver license # helps prevent identity theft & we are legally required to verify your identity.

Address _____

City _____ State _____ Zip _____

Patient Ph. _____ Work Ph. _____ Patient Cell Ph.* _____ Text: yes / no

*Patients over 18 & over should list their own contact information

Patient Email _____

Gender _____ Age _____ Marital Status: Single Married Widowed The Patient is a Dependent Child

If the Patient is a dependent child, what is your relationship to the child? _____

Patient Employed by _____ Occupation _____

Who may we contact in case of emergency? _____ Relationship _____ Ph# _____

PATIENT INSURANCE

Please select any of the following that apply:

_____ I am a current patient.

_____ I am a new or returning patient.

_____ I don't have insurance & will be paying by cash / credit.

____ **Yes**, my dental insurance has changed. **(ALERT THE FRONT DESK PRIOR TO BEING SEEN.)**

____ **No**, my dental insurance has not changed. **(YOU CAN SKIP TO THE NEXT SECTION.)**

Primary Dental Insurance Company _____ Employer _____

Member ID# _____ Group # _____ Ins Company Ph # _____

Name of policy holder _____ Policy holder DOB _____

Relationship to Patient _____ Policy holder SSN _____ Policy holders Ph # _____

Have you used these dental benefits at any other office this year? Yes / No If yes, where? _____

Secondary Dental Insurance Company _____ Employer _____

Member ID# _____ Group # _____ Ins Company Ph # _____

Name of policy holder _____ Policy holder DOB _____

Relationship to Patient _____ Policy holder SSN _____ Policy holders Ph # _____

Have you used these dental benefits at any other office this year? Yes / No If yes, where? _____

HEALTH INFORMATION

- Have you ever taken any bone enhancing medications containing bisphosphonates such as Fosamax, Boniva or Actonel**? Yes No

If yes, was it an **oral medication or IV Infusion? When were they taken & for how long? _____

- Do you take any medications? Yes No If yes, please list all of your medications, **even over the counter medications & supplements**.

_____

_____

_____

- Do you take a blood thinner or a daily aspirin? Yes No _____

____ Check here if you have a medication list that we can scan and return to you. (Please let the front desk know.)

- Does your surgeon prescribe an antibiotic for you to take prior to your dental appointments? _____

- What is the name & phone number of your pharmacy, should we need to call in any medications for you? **(Please list a local pharmacy number.)**

_____

OVER PLEASE

Are you under a physician's care for any specific medical condition? Yes No If yes, please explain_____

Have you recently been hospitalized or had a major operation? Yes No If yes, please explain_____

Have you had a serious head or neck injury? Yes No If yes, please explain_____

Do you use tobacco? Yes No If yes, Smoke Dip Chew How much? _____

Have you ever been addicted to prescription or illegal drugs? _____

WOMEN:

____ Not Pregnant _____ Pregnant: Due Date: _____ _____ Nursing

____ Taking Contraceptives. Please indicate what kind: _____

ALLERGIES:

___ No Known Allergies ___ Latex ___ Codeine ___ Acrylic

___ Aspirin ___ Penicillin ___ Sulfa Drugs ___ Local Anesthetics

___ Metal / Nickel ___ Amoxicillin

Any additional allergies not listed above? Yes No If yes, please explain _____

CIRCLE ALL THAT APPLY:

Acid Reflux
ADD / ADHD
AIDS / HIV +
Alzheimer's Disease
Anaphylaxis/Severe
Allergic Reaction
Angina/Chest Pains
Arthritis
- Osteo
-Rheumatoid
Artificial Heart Valve
Artificial Joint
-Surgery Date: _____
-Which Joint: _____
_____
Asthma
Autism
Blood Disease
Blood pressure; High
Blood pressure; Low
Bruise Easily
Cancer
-What Kind: _____
-When?:_____
-Chemotherapy?_____
-When?:_____
-Radiation?_____
-When?:_____
Chest Pains
Cold Sores/Fever Blisters
COPD
Cortisone Medicine
Past or Present
Dementia
Diabetes Type 1
Diabetes Type 2
Dry Mouth
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Fainting Spells / Dizziness
/ Vertigo
Frequent Headaches
Glaucoma
Heart:
A-fib
Heart Disease
Heart Attack
Irregular Heartbeat
Mitral Valve Prolapse
Murmur
Pacemaker
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Cholesterol
Hives or Rash
Hyperglycemic
Hypoglycemic
Kidney Problems
Lung Disease
Migraine
Osteoporosis
Pain in Jaw Joints
Parkinson's
Psychiatric Care
Rheumatic Fever
Shingles
Sleep Apnea
CPAP user? Yes No
Sinus Trouble / Seasonal
Allergies
Stomach / Intestinal
Disease / IBS
Stroke
Thyroid Disease:
Hypothyroidism
Hyperthyroidism
Parathyroid Glands
Tonsillitis
Tuberculosis
Active or Inactive?
Tumors or growths

Have you had any other serious illness or condition not listed above? Yes No If yes, please explain _____

RESPONSIBLE PARTY

Consent for Services: **I understand that I am financially responsible for all charges whether or not paid or allowed by insurance.** As a condition of my treatment by this office, I understand that payment is due at the time of service. Patients with or without dental insurance will be asked to pay their estimated portion at the time of service. As a courtesy, our office will submit claims to your dental insurance company on your behalf. You are responsible for notifying the office about any changes to your insurance policy. ***Individual yearly maximums are typically shared by any dental specialist that is billing your insurance & any services received outside this office will affect any estimates presented to me. I understand that dental plans do not offer "free cleanings" as all services are paid from my yearly maximum.*** Predeterminations are only done at the patients request & do not guarantee benefits. Any balance carried more than 90 days can be sent to a third party collector & could be subject to administrative fees. Insurance termination dates can be backdated & in network rates would not apply if this is the case.

Parents, Guardians or others bringing minors to appointments: By bringing the patient to the office to receive care, I understand that as the person requesting that the Providers at Ross Dental Group render care to the minor, I am responsible for the charges that result from said care. If there are any prior financial arrangements via court order or verbal arrangement, those arrangements are between those entities, not between Ross Dental Group and the Patient or the Responsible Party.

HIPAA: Notice of our HIPAA is clearly posted in our reception room as mandated by law. Your signature on this form is your acknowledgement of that. If you would like a written copy of our specific HIPAA policies, please ask an administrative member of our team.

I understand that Ross Dental Group asks for 48 business hours to cancel or change an appointment to avoid the $75 cancellation fee. I am aware that Ross Dental Group sends multiple reminders via text & email to help remind me about my appointments.

X

Patient (or Guardian) Signature **Patient's** Printed name If Applicable, Guardian's Name/Relationship to Patient Date