Welcome to Ridgetop Dental!

We're so excited to begin our partnership with you! To ensure we have the information we need to best serve you, please take a few moments to fill out the form below. If you have any questions, please feel free to contact us at any time. Thank you!

21631 Ridgetop Circle, Suite 240, Sterling VA 20166

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MI): ______________________ **WHAT DO YOU PREFER TO BE CALLED?:** ______________________

DATE OF BIRTH: ______________ **SEX:** ❑ Male ❑ Female **EMAIL ADDRESS:** ______________________

ADDRESS: ____

APT. #: __________ **CITY:** ______________ **STATE:** __________ **ZIP:** __________

S.S.N.: ______________ **MARITAL STATUS:** ❑ Married ❑ Single ❑ Divorced ❑ Widowed

HOW DO YOU PREFER WE CONFIRM YOUR APPOINTMENTS?: ❑ Text ❑ Email

PATIENT'S HOME PHONE NUMBER: ______________ **ALTERNATIVE PHONE NUMBER:** ______________ ❑ Cell ❑ Work

PATIENT EMPLOYER: ______________ **EMPLOYMENT STATUS:** ❑ Full time ❑ Part Time ❑ Unemployed ❑ Retired ❑ Student

Other: ______________________________

EMERGENCY CONTACT NAME: ______________ **RELATIONSHIP TO PATIENT:** ______________ **PHONE NUMBER:** ______________

ARE THERE MEMBERS OF YOUR FAMILY SEEN IN OUR OFFICE: ❑ Yes ❑ No

PLEASE LIST: ______________________________

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE):

No. VA Magazine	Google	Dulles Chamber
Newspaper	Yahoo	Loudoun Chamber
Postcard / Mailer	Insurance Website	Family / Friend (name)

Other: ______________________________

I'M INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING DENTAL SERVICES: (PLEASE CIRCLE):

Cosmetic Consultation	Sedation Dentistry	Teeth-In Same Day
Cosmetic Veneers	Cerec® "One Visit" Crowns	Dental Implants
Invisalign®	Bonding	Trial Smile
Performance UA Mouth Guards	Whitening	Smile Design
Financing Options	General Dentistry	Other

DENTAL HISTORY

LAST DENTAL VISIT? ______________________

HOW WOULD YOU DESCRIBE THE CONDITION OF YOUR TEETH AND GUMS?

❑ Poor ❑ Fair ❑ Good

DO YOU HAVE SENSITIVE TEETH? ❑ Yes ❑ No

DO YOU GRIND OR CLENCH YOUR TEETH? ❑ Yes ❑ No

HAVE YOU BEEN TREATED FOR TMJ? ❑ Yes ❑ No

HAVE YOU EVER EXPERIENCED PAIN IN YOUR JAW JOINT? ❑ Yes ❑ No

HAVE YOU EVER BEEN TREATED FOR SLEEP APNEA? ❑ Yes ❑ No

MANY PATIENTS CONSULT US FOR A SECOND OPINION.
ARE YOU CURRENTLY SEEING ANOTHER DENTIST FOR YOUR DENTAL NEEDS? ❑ Yes ❑ No

HOW OFTEN DO YOU BRUSH YOUR TEETH? (PER DAY)

❑ 1 Time ❑ 2 or More

DO YOUR GUMS BLEED WHEN YOU BRUSH OR FLOSS?

❑ Yes ❑ No

HOW OFTEN DO YOU FLOSS YOUR TEETH?

❑ Daily ❑ Weekly ❑ Rarely

ARE YOU CURRENTLY IN PAIN OR DISCOMFORT WITH YOUR TEETH OR GUMS? ❑ Yes ❑ No

If Yes, please explain: ____

____

____

WHY DID YOU CHOOSE TO VISIT OUR OFFICE TODAY? (CIRCLE ALL THAT APPLY):

Dental Emergency/ I'm in Pain
Second Opinion
Want to Maintain Oral Health
Establish a New Dentist
Interested in Cleaning
Promotion/Coupon

Another doctor referred me to your office, please list: ______________________________

Interested in a particular service not listed above: ______________________________

DESCRIBE YOUR FEAR TOWARDS DENTAL VISITS AND TREATMENTS (PLEASE CHECK):

❑ None ❑ Mild ❑ Moderate ❑ Severe

Please explain if you checked Mild, Moderate, or Severe.
What makes you phobic of going to the dentist? What past experiences have made you fearful of dental visits?

____

MEDICAL HISTORY

YOUR CURRENT PHYSICAL HEALTH IS:

❑ Poor ❑ Fair ❑ Good

DO YOU SMOKE OR USE TOBACCO IN ANY FORM?

❑ Yes ❑ No

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? ❑ Yes ❑ No

If Yes, please explain: ____

ARE YOU TAKING ANY PRESCRIPTION/OVER THE COUNTER DRUGS? ❑ Yes ❑ No

If Yes, please explain: ____

HAVE YOU OR DO YOU TAKE FOSAMAX, BONIVA, ACTONEL, OR RECLAST? ❑ Yes ❑ No

FOR WOMEN:

ARE YOU TAKING BIRTH CONTROL PILLS? ❑ Yes ❑ No

ARE YOU PREGNANT? ❑ Yes ❑ No

If Yes, what week? __________

ARE YOU NURSING? ❑ Yes ❑ No

HAVE YOU EVER HAD THE FOLLOWING DISEASES OR MEDICAL PROBLEMS (*PLEASE CHECK YES or NO*) :

Abnormal Bleeding:	❑ Yes	❑ No	Epilepsy:	❑ Yes	❑ No	Mitral Valve prolapse:	❑ Yes	❑ No
Alcohol Abuse:	❑ Yes	❑ No	Fainting Spells:	❑ Yes	❑ No	Nervous / Anxious:	❑ Yes	❑ No
Anemia:	❑ Yes	❑ No	Frequent Headaches:	❑ Yes	❑ No	Pacemaker:	❑ Yes	❑ No
Angina Pectoris:	❑ Yes	❑ No	Glaucoma:	❑ Yes	❑ No	Psychiatric Problems:	❑ Yes	❑ No
Arthritis:	❑ Yes	❑ No	Hay Fever:	❑ Yes	❑ No	Radiation Treatment:	❑ Yes	❑ No
Artificial Bones/Joints:	❑ Yes	❑ No	Heart Attack:	❑ Yes	❑ No	Rheumatic / Scarlet Fever:	❑ Yes	❑ No
Artificial Heart:	❑ Yes	❑ No	Heart Murmur:	❑ Yes	❑ No	Seizures:	❑ Yes	❑ No
Asthma:	❑ Yes	❑ No	Hemophilia:	❑ Yes	❑ No	Shingles:	❑ Yes	❑ No
Blood Transfusions:	❑ Yes	❑ No	Heart Surgery:	❑ Yes	❑ No	Sickle Cell Disease:	❑ Yes	❑ No
Cancer / Chemotherapy:	❑ Yes	❑ No	Hepatitis:	❑ Yes	❑ No	Stroke:	❑ Yes	❑ No
Colitis:	❑ Yes	❑ No	High Blood Pressure:	❑ Yes	❑ No	Sinus Problems:	❑ Yes	❑ No
Congenital Heart Defect:	❑ Yes	❑ No	HIV+ / AIDS:	❑ Yes	❑ No	Thyroid Problems:	❑ Yes	❑ No
Diabetes:	❑ Yes	❑ No	Kidney Problems:	❑ Yes	❑ No	Tuberculosis:	❑ Yes	❑ No
Difficulty Breathing:	❑ Yes	❑ No	Liver Disease:	❑ Yes	❑ No	Ulcers:	❑ Yes	❑ No
Drug Abuse:	❑ Yes	❑ No	Latex Allergy:	❑ Yes	❑ No	Venereal Disease:	❑ Yes	❑ No
Emphysema:	❑ Yes	❑ No	Low Blood Pressure:	❑ Yes	❑ No	Yellow Jaundice:	❑ Yes	❑ No

Please list any other serious medical conditions that you have had:

____

ARE YOU ALLERGIC TO THE FOLLOWING?:

Aspirin:	❑ Yes	❑ No	Codeine:	❑ Yes	❑ No	Dental Anesthetics:	❑ Yes	❑ No
Erythromycin:	❑ Yes	❑ No	Latex:	❑ Yes	❑ No	Penicillin:	❑ Yes	❑ No
Tetracycline:	❑ Yes	❑ No	Other:	❑ Yes	❑ No			

Please list any other **drugs** you are allergic to:

____

DENTAL INSURANCE

Insured's Name: ______________________________

Insured's Subscriber ID: ______________ Insured's Birth Date: ______________

Insured's Employer: ______________ Relation to Patient: ______________

Dental Benefits Name: ______________________________

Dental Benefits Address: ______________________________

Phone Number: ______________ Group # (Plan, Local, or Policy #): ______________

** Please Note: Without this information, we may not be able to submit a claim to your dental benefits on your behalf.*

FINANCIAL POLICY

The undersigned hereby authorizes the release of any information requested by the dental benefits designated above and authorizes payment by such dental benefits of medical benefits to Ridgetop Dental for services rendered. **The under-signed agrees to be ultimately responsible for payment of all charges for services rendered by Ridgetop Dental whether or not such services are covered by insurance benefits.** HMO/PPO plan participants are fully responsible for their designated co-pay. The undersigned agrees to reimburse Ridgetop Dental for any expenses, incurred in connection with the collection of sums due for services performed here under.

If you have dental insurance, we will assist you to maximize your insurance benefits, and are happy to file claims to your insurance carrier for free. We agree to accept payment from any carrier that offers an assignment of benefits, if you desire. Our office will do our best to provide you with an **estimate** of your out of pocket expenses. Please note that this is just an estimate and is given to our office from your dental benefits. **I understand that the estimate of my co-payment, deductible, and charges not covered by insurance are due at the time you schedule your appointment to reserve that appointment time. This estimate is not a guarantee of benefits. Please familiarize yourself with your specific plan as certain limitations may apply. I understand that I am responsible for any portion not paid by my insurance.**

Have you contacted your dental benefits for verification of benefits?

☐ Yes ☐ No

Patient Signature: **Date:**

HIPAA POLICY

Our notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our Notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Ridgetop Dental.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I give consent to release my health information to discuss treatment plans and finances to the following family members (please list all):

Patient Signature (Must Be Done In Person): **Date:**

Witness Signature: