PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

1

DATE

NAME

SPOUSE

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED

SOCIAL SECURITY NO.

DATE

NAME

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYEE

DATE OF BIRTH | DATE EMPLOYED

UNION OR LOCAL NO.

EMPLOYEE NO.

EMPLOYEE SOCIAL SECURITY NO.

3 GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME | RELATIONSHIP

REFERRED TO US BY

YOUR FORMER ADDRESS

CITY | STATE | ZIP

PERSON TO CONTACT FOR EMERGENCY

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY | STATE | ZIP

4 ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP TO PATIENT

ADDRESS

CITY | STATE | ZIP

PHONE NO.

YOU

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

YOUR SPOUSE

NAME

OCCUPATION

EMPLOYER

BUSINESS ADDRESS | CITY

BUSINESS PHONE NO. | EXT.

PLEASE TURN OVER AND SIGN

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a through diagnosis of (name of patient) _____ 's dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

_____

_____

(Please complete other side)

Patient Name	
Patient Account No.	Medical Alert

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? ..... Yes No
3. Are you taking any medication, drugs or pills now? ..... Yes No
   If yes, please list name and dosage _____
4. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artifical Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/ Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? ..... Yes No
8. Have you lost or gained more than 10 pounds in the past year? ..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed? ..... Yes No
   If yes, please list: _____
10. **Women.** Are you: **Pregnant?** Yes, ___ Months No **Nursing**? Yes No **Taking birth control pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____ Date _____

History Review

Doctor Signature _____ Date _____

Ronald E. Richardson, Jr., DDS, PA
1704 Airport Boulevard, Suite A
Melbourne, FL 32901
321 -723-3477

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Ronald E. Richardson, Jr., DDS, PA. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Ronald E. Richardson, Jr., DDS, PA reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below				
ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY):		YES		NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not Obtained		
PROVIDED PRIOR TO TREATMENT?		**YES**
		NO
DATE PROVIDED:		
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
		UNABLE TO SIGN.
		REASON NOTGIVEN.
		OTHER (EXPLAIN):

STATEMENT OF PRIVACY PRACTICES

Ronald E. Richardson, Jr., DDS, PA
1704 Airport Boulevard, Suite A
Melbourne, Florida
321-723-3477

Our office is dedicated to protect the privacy rights of our patients and the confidential information en trusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Port ability and Accountability Act and the state of Florida. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone — even family members — without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain in formation from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of for mats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Ser vices.

We thank you for being a patient at Ronald E. Richardson, Jr., DDS, PA. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Ronald E. Richardson, Jr., DDS, PA

WHAT YOU CAN EXPECT FROM DR. RICHARDSON AND HIS TEAM

- **THOROUGH EVALUATION:** In order for us to help you attain a healthy mouth, we need to do a complete and comprehensive exam. This consists of checking your joints, muscles, gums, teeth, bite, and a full oral cancer screening. We also evaluate your health history and how it impacts your oral health, and study your previous dental work. We usually take a full set of radiographs (x-rays), and diagnostic photography. With this information, Dr. Richardson will form a treatment plan customized for your health.

- **NOT ALL DENTAL WORK IS CREATED EQUAL:** It can be difficult to hear that the prior dental work in your mouth is failing. Whether it is due to excessive wear, time, or poor quality, the fact is that it may not last forever. Dr. Richardson's commitment and obligation to you is to tell you the way it is now, and what we can do to bring your mouth to perfect health.

- **TREATMENT PLAN:** We are dedicated to bringing your mouth to a state of health that you will be able to maintain for a lifetime. We will listen to you and form a personal treatment plan for you. This can include a plan for maintenance, a plan for restoration, and if you wish, a plan for cosmetics. Everything that Dr. Richardson recommends will be explained, and the decision as to how to proceed will be left up to you. Shannon will be your liaison, and will guide you through your planning and answer your questions regarding financing, scheduling, and procedures.

- **HYGIENE:** Hygiene is the backbone of dental health. There is a constant battle going on in your mouth with the bacteria that live there. There are places in your mouth that you can't get to, and even the best home care is not enough. The most cost effective way to keep your mouth healthy is to have regular professional cleanings. We have two dedicated and talented hygienists who will care for your professional hygiene needs, and educate you regarding your home care.

- **TIME:** We understand the value of time. With Kit's expertise in scheduling, your appointment will be reserved for the best time that works for you. Dr. Richardson is committed to one patient at a time to ensure you leave with a full understanding of your dental plan to keep you healthy. **No cancellation fee will be assessed for a change if it is made 2 business days prior to your appointment.**

- **PAYMENT:** Fees are due at the time of service. If you have dental insurance, our business administrators are experts at helping you to maximize your insurance benefits. As a courtesy to you, we will file your insurance claims for you, and your insurance company will pay you, or Dr. Richardson, according to the terms of your policy. For major treatment, you may be asked to provide a down-payment in order to reserve your appointment. We accept MasterCard, Visa, and Discover, as well as Debit, Cash, or Checks. Returned checks will be assessed service fees.

- **REFERRALS:** Dr. Richardson works closely with many talented local dental specialists. His journey has led him to focus mainly on dental restorative and cosmetic procedures. If you require a special procedure that Dr. Richardson feels would be best performed by a specialist, referral options will be discussed.

- **CELL PHONES:** In order to provide focused one on one care, we ask that you please turn off your cell phone. If you are expecting an important phone call, please turn your phone to vibrate, or ask for the assistance of a team member.

- **THANK YOU:** We appreciate you choosing us to care for your dental needs. Your referrals of friends, neighbors and family is one of the finest compliments that we can receive. Ask us today about our referral reward program.

Dr. Ronald E. Richardson, Jr., D.D.S., P.A.
We Go The Extra Mile To Make You Smile!
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www.MelbourneCosmeticDentist.com