The RICCO DENTAL Group

Welcome! Please take a moment to help us get to know you better!

Patient Information:

Name_____ Social Security#_____

Address_____ D.O.B_____

City_____ Zip_____ Sex ___M____F Marital Status_____

Occupation :_____

We confirm through text and e-mail. Please provide us with as many devices possible to reach you when needed:

Home Phone_____ Work _____ Mobile_____
Email_____ Additional_____

Insurance Information:

Primary Dental Coverage

Carrier name:_____

Subscriber Name:_____

Subscriber S.S#_____DOB_____

Secondary Dental Coverage

Carrier name:_____

Subscriber Name:_____

Subscriber S.S#_____DOB_____

Reason for today's visit:_____

Who may we thank for referring you?_____

The Ricco Dental Group requires 24hrs notice to cancel appointment without penalty. We dedicate adequate time for the doctor/hygienist to care for you without interruption. When appointments are broken without sufficient notice it significantly hinders our productivity as an office. There will be a $45.oo charge for appointments that are failed without proper notice. Please initial below that you have read our policy.

Initial _____

Payment is expected the day services are rendered, unless a prior arrangement has been determined. We will estimate insurance payments to make sure you are aware and accepting of your out of pocket expense prior to treatment. Please be aware that our estimates are based off of a guideline given to us from your coverage. The insurance does not guarantee payment until services are rendered. We accept Cash, Checks, Visa, MasterCard, American Express, Care Credit and most flex accounts with credit card logos.

Signature of person financially responsible for this account: **X**_____
Name and relation to responsible party if patient is minor_____

For your convenience and to avoid billing fees we would prefer to keep a credit card on file for any balances not paid by your insurance within 45 days.
I authorize the office of Dr, Ricco to keep my signature on file and charge my _____ if my balance if 45 days past due.

Card Holder Name_____ Billing zip code_____
Account # Expiration Date Security code
Card holder Signature _____ Date_____

Dental Health History

Last dental visit_____ Dentist seen_____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING PROBLEMS?

Bleeding gums?	**Y**	**N**	Sensitivity to Hot or Cold?	**Y**	**N**
Bad breath or sour taste in your mouth?	**Y**	**N**	Snoring?	**Y**	**N**
Burning sensation in your mouth?	**Y**	**N**	Food catching between teeth?	**Y**	**N**
Is it hard for you to open wide?	**Y**	**N**	Grinding of teeth?	**Y**	**N**
Clicking or popping in jaw?	**Y**	**N**	Pain/Soreness around ears, eyes, face?	**Y**	**N**
Have a family history of gum disease?	**Y**	**N**	Stiff neck muscles?	**Y**	**N**
Ever been injured in your mouth or head?	**Y**	**N**	Did your parents wear dentures/partials?	**Y**	**N**
Oral Surgery of any kind?	**Y**	**N**	Did you ever wear braces?	**Y**	**N**
Soreness in jaw?	**Y**	**N**	Do you smoke or chew tobacco?	**Y**	**N**

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE WHICH WOULD YOU WANT?

Whiter?	**Y**	**N**	Excess showing of teeth/ gums?	**Y**	**N**
Replace missing teeth?	**Y**	**N**	Reshape/ Resize teeth?	**Y**	**N**
Remove stains / spots on teeth?	**Y**	**N**	Replace chipped teeth?	**Y**	**N**
Straighter?	**Y**	**N**	Remove silver fillings?	**Y**	**N**
Close space or spaces?	**Y**	**N**	Replace old crowns/ veneers?	**Y**	**N**

Medical History

Name of your Physician_____ Phone #_____

Have you been hospitalized in the last 5 years? If so, for what?_____

_____

Any Allergies or reactions to medication/ latex?_____

Have you had an orthopedic total joint replacement? (Hip, Knee, Elbow, Finger)_____

_____

Currently taking medications? Please list_____

_____

Please (X) a response to indicate if you currently have or have ever experienced any of the following:

Diabetes		Alcohol addiction		Women only: pregnancy / nursing	
Cancer / Tumors		Recreational drug addiction		Women only: birth control	
Anemia		TB, emphysema or other lung disease		chemotherapy	
Thyroid, adrenal diseases		Bleeding problems / bruising easily		Radiation treatment	
Heart disease		Chest pains		Pace maker	
Heart attack / defect		Dizziness / vertigo		Prosthetic heart valve	
Heart murmur		Swollen ankles		Artificial joint	
Rheumatic fever		Seizures		Blood transfusion	
Stroke, hardening of arteries		Dry mouth		Sinus problems	
High blood pressure		Jaundice		Shortness of breath	
Stomach problems/ ulcers		Sleep apnea		Frequent Headaches	
Arthritis, rheumatism		Kidney, bladder disease		Sexually transmitted disease	
Eye disease		Hepatitis A B C		Herpes	
Skin disease		TB ,emphysema or other lung disease		HIV Positive	
Reaction to general anesthesia		Reaction to local anesthesia		Food / drug allergies	

Please explain any above that has been checked _____

_____

TO ASSURE I RECEIVE THE BEST POSSIBLE CARE, I HAVE DISCLOSED ANY AND ALL MEDICAL CONDITIONS TO THE BEST OF MY KNOWLEDGE.

DATE_____ Signed_____