Ramsey Family Dentistry
Kevin Ramsey, D.M.D.

Today's date:	Dr. Kevin Ramsey 480-207-6001

PATIENT INFORMATION

Patient's Name:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
E-Mail	Birth date: / /	Age:	Sex: ❑ M ❑ F
Text and Email reminders: Yes _____ NO _____			
Street address:	Social Security no:		Home phone no: ( )
City	State	Zip Code	Cell Phone ( )
Occupation:	Employer:		Employer phone no.: ( )
Who can we thank for referring you?			
Person financially responsible:	DOB:		SOC:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Subscriber's Name:	Birth date: / /	Address (if different):	Cell:
Dental: ***PRIMARY INSURNACE:***	Employer:	***Subscriber's S.S. no or ID:***	DOB: / /
Insurance Phone number:			
Dental: ***SECONDARY INSURNACE:***			

Subscriber's Name:	Employer:	***Subscriber's S.S. or ID:***	DOB: / /		
Insurance Phone number:					
Patient's relationship to subscriber:					

IN CASE OF EMERGENCY

Name of local friend or relative (**not living at same address**):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Ramsey Family Dentistry or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

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Today's date:

Dental History

Cell: Email: SSN:

Patient's Name: DOB:

Reason for today's visit:

Date of last dental cleaning: Did they take x-rays at that time?

Mark if you have or have ever had any of the following:

___Bad breath ___ Loose or broken teeth ___Bleeding gums
___ Clicking or popping jaw ___ Sensitivity to hot or cold ___ Food collecting between teeth

Medical History

Physicians Name:

List any serious illnesses or operations? _____

Has it ever been necessary for you to pre-medicate (take antibiotics) before a dental appointment?_____

Any of the following conditions past or present?

Anemia	Yes/No	Artificial heart valves	Yes/No	Artificial joints	Yes/No
Blood disease	Yes/No	Cancer	Yes/No	Chemotherapy	Yes/No
Chemical dependency	Yes/No	Circulatory problems	Yes/No	Diabetes	Yes/No
Epilepsy	Yes/No	Heart problems	Yes/No	Heart murmur	Yes/No
Bleeding disorder	Yes/No	High blood pressure	Yes/No	Hepatitis	Yes/No
HIV	Yes/No	Kidney disease	Yes/No	Mitral valve prolapse	Yes/No
Pacemaker	Yes/No	Rheumatic fever	Yes/No	Scarlet fever	Yes/No
Shortness of breath	Yes/No	Stroke	Yes/No	Swelling feet / ankles	Yes/No
Thyroid problems	Yes/No	Tobacco use	Yes/No	Cholesterol	Yes/No
Asthma	Yes/No	Vaping	Yes/No		

Women: Are you pregnant? yes / no Are you Nursing? yes / no Taking birth control? yes / no

Explanation for any yes answers:

List any medications you are currently taking: _____

List any allergies you are aware of: _____

To the best of my knowledge, the above information is accurate and complete. I will not hold the doctor or any members of the staff responsible for any errors or omissions I may have made in the completion of this form.

Patient Name: Doctor's Signature:

Patient/Guardian Signature: Date:

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Dr. Kevin Ramsey 480-207-6001

Ramsey Family Dental is committed to providing you with the best dental care available. We have found that a clear understanding of our office guidelines can relieve some of the anxiety associated with going to the dentist. We want to be certain that all of your questions are answered to your satisfaction. For your convenience we honor several different insurance plans. Your treatment in our office is guaranteed, as long as you maintain your recommended hygiene visits.

Payment options:
We gladly accept Cash, MasterCard, Visa, Discover and AMEX for your convenience. Also, when you do not have dental insurance, we ask that you pay for your dental services in full at your appointment. I authorize Ramsey Family Dentistry to charge the card number on file for any unpaid balance over 60 days.

Dental Insurance:
As a courtesy to you we will file your insurance claim. We will make a good faith estimate for your planned treatment and request that you pay your estimated portion at the time of service. Please be aware that you are solely responsible for your account, including any unpaid portion by your insurance.
We will make every effort to help you obtain your full benefit amount from your insurance carrier. If your insurance denies a claim and is unresolved after 60 days of the filing day, the entire amount will become due and payable by you.

Post Card Special:
After first cleaning patients have option to purchase In Office Membership Program or pay office fee's for additional services. For any questions please speak with front office staff.

Financial services:
We offer ***Care Credit*** for those who would like to pay overtime with convenient monthly payments, including several interest deferred options. We also carry an in office discount plan for those without the benefit of dental insurance.

Please take into consideration; our office requires a minimum of 48 business hours' notice, if you need to make changes to your scheduled appointment.

Your appointment is specifically reserved for you. *There can be a $50.00 per hour of missed appointment time charge, without proper notice. A missed Saturday appointment will not be rescheduled to another Saturday.*

There is a $25.00 charge for unpaid returned checks.

I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical information requested by my insurance carrier in order to receive payment on a claim. I hereby agree that in the event of default of any amount due, and if this account is placed with a collection agency or attorney fees incurred to be paid in addition the to the outstanding amount on account.

Signature of Patient / Guardian _____

Printed Name: _____ Date: _____

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Privacy Policy/HIPAA Compliance

We understand that medical information about you and your health is personal "Protected Health Information" ("PHI") and we are committed to protecting your medical information.

Treatment:

We may disclose PHI to your insurance provider, our dentist(s), and other dental care providers for treatment purposes. For example, your dentist may wish to provide a dental service to you but first seeks information from your insurance provider as to whether the service has been previously provided.

Payment:

We disclose your PHI in order to fulfill our duty to check your coverage, determine your benefits, and secure payment for services provided to you. For example, we use your PHI in order to request process of your claims by your insurance provider.

Health Care Operations:

We may be asked by the sponsor of your health plan to provide your PHI to the sponsor. If we are asked to do so, we intend to honor such requests unless we are prohibited by law. Subject to certain requirements, we may give out PHI without your authorization for public health purposes, auditing purposes, research studies, and emergencies. We provide PHI when otherwise required by law, such as for law enforcement in specific circumstances, or for judicial or administrative proceedings.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and send the new notice to you. You can also request a copy of our notice at any time.

Individual Rights

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we have made about access to your records, you may contact the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. Customer Service can provide you with the appropriate address upon request.

Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice. If you wish to inspect your records, receive a listing of disclosures, or correct or add to the information in your record, or if you have any questions, complaints, or concerns, please contact our office.

Signature:_____