DATE: _____

Dr. William Ralstin, DDS, PA
Family & Cosmetic Dentistry

Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

NAME: _____ I LIKE TO BE CALLED: _____
Last First Middle

BIRTH DATE: _____ **EMAIL ADDRESS: _____**
MM/DD/YY **□ Single □ Married □ Divorced □ Widowed**

ADDRESS: _____
Street Apt# City State Zip

TELEPHONE: _____ /_____ SOCIAL SECURITY#_____
Home Cell

PLACE OF EMPLOYMENT: **_____ WORK # _____**

Has any member of your family ever been treated in our office? □ Yes □ No If yes, who?_____

Whom may we thank for referring you to our office? (check all that apply)
□ Newspaper □ I saw your sign □ Yellow Pages □ Magazine □ Direct Mail □ Internet
□ Acquaintance: _____ □ Another Dr.:_____

Insured Information	**Responsible/Billing Party Information**
Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other	Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other
Last First MI	Last First MI
Street Address City ST Zip	Street Address City ST Zip
Home/Cell Telephone # Birth Date (MM/DD/YY)	Home Telephone # Cell Telephone #
Employer Dental Insurance Company	Email Address Birth Date (MM/DD/YY)
Insured Social Security # or Insured ID# (if different than social)	Drivers License # Social Security #
Insurance Mailing Address	Employer Work Telephone #
Ins Phone Number Group/Plan Number	

PERSON TO CONTACT INCASE OF EMERGENCY

Name: _____Telephone Number: _____
Relationship:_____

May we leave messages announcing our office name in regards to appointments, treatment, and/or insurance/financials on your voicemail? □YES □NO □YES, with exceptions:_____

Please Continue to next page...

Medical History

It is important for your safety that I know about your medical and dental history. This information is strictly confidential and will not be released to anyone without your consent. Thank you for taking the time to honestly and accurately complete this questionnaire. Please review this list carefully and check any of the following that you have, or had in the past.

__ Acid Reflux
__ AIDS
__ Alcoholism
__ Angina (chest pains)
__ Arthritis
__ Artificial heart valve
__ Artificial joint (hip, knee, etc)
__ Asthma
__ Atrial Fibrillation
__ Bleeding disorders
__ Blood transfusion
__ Cancer
__ Congenital heart defect
__ Congestive heart failure
__ Diabetes
__ Drug addiction
__ Emphysema
__ Epilepsy or seizures
__ Fainting spells
__ Glaucoma
__ Gout
__ Heart Attack
__ Heart Murmur
__ Heart Pacemaker
__ Heart Trouble
__ Hepatitis A (infectious)
__ Hepatitis B (serum)
__ Hay fever
__ Head or Neck Injury
__ High Blood Pressure
__ Kidney Trouble
__ Liver Disease
__ Low Blood Pressure
__ Marked weight gain
__ Migraines
__ Organ Transplant
__ Psychiatric treatment
__ Rheumatic fever
__Rheumatic heart disease
__ Shortness of breath
__ Sinus trouble
__ Smoking/Tobacco
__ Steroid therapy
__ Stroke
__ Thyroid problems
__ Tumors and growths
__ Ulcers
__ Vascular graft
__ Venereal disease
__ Xray or Cobalt

Do you have any current health problems? ____yes ____no

Are you under a physician's care now? ____yes ____no

If so, for what?_____

Have you ever been hospitalized, or had a serious illness or operation? ____Yes ____No

If so, please explain when and why_____

Physicians name:_____Phone#_____

Date of last medical exam_____

Have you ever been told you need to PRE-MEDICATE for any dental services? _____YES _____NO

IF YES, PLEASE EXPLAIN_____

Please check any of the following types of medications you are taking:

__Antibiotics
__Blood thinners
__Blood pressure medication
__Thyroid medication
__Cortisone/Steroids
__Heart medication
__Insulin
__Other Diabetic medication
__Nitroglycerine
__Asthma medication
__Psychiatric medications
__Birth control pills
__Antihistamine
__Pain medication
__Hormone therapy
__Antidepressants
__Sedatives
__Tranquilizers

Please list the name & dosage of ALL medications (including VITAMINS) you are taking:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Please check any of the following drugs to which you have had an allergic reaction:

__Penicillin	__Aspirin	__Nitrous Oxide gas
__Sulfa	__Codeine	__Other drugs
__Any antibiotics	__Other Narcotics	__Iodine
__Local anesthetics (Novocaine, etc)	__Latex	

Do you have any other significant allergies (food, bee stings, fur, etc) ___Yes ____No. If so, please list_____

Women: Are you pregnant? ____yes ____no If so, when is baby due?_____

Please explain any other disease, condition or problem not mentioned on this form that you think we should know about

_____

Patient Dental History

1. Do your gums bleed while brushing or flossing?..... ____Y____N
2. Are your teeth sensitive to hot or cold liquids/foods?..... ____Y____N
3. Are your teeth sensitive to sweet or sour liquids/foods?..... ____Y____N
4. Do you feel pain to any of your teeth?..... ____Y____N
5. Do you have any sores or lumps in or near your mouth?..... ____Y____N
6. Have you had any head, neck or jaw injuries?.....____Y____N

7. Have you ever experienced any of the following in your jaw?
   a.Clicking?.....____Y____N
   b.Pain (joint, ear,side of face)?.....____Y____N
   c.Difficulty in opening or closing?.....____Y____N
   d.Difficulty in chewing?.....____Y____N

8. Do you have frequent headaches?.....____Y____N
9. Do you clench or grind your teeth?.....____Y____N
10. Do you bite your lips or cheeks frequently?.....____Y____N
11. Have you had any orthodontic work?.....____Y____N
12. Do you snore?.....____Y___N
13. Have you ever had a sleep study?.....____Y____N
14. Do you wear a CPAP or any type of appliance?.....____Y____N

Signature_____ Date_____

Our primary responsibility to you is to provide quality dental care. To maintain this standard of care, we believe that it is in the best interest of everyone to establish a patient account policy up front to avoid any misunderstandings. We will provide you with a written estimate of your financial investment prior to any treatment being rendered. Treatment estimates quoted are good for 90 days from the date of the estimate.

1. **PAYMENT IS EXPECTED ON THE DATE OF SERVICE**…In some instances, we may ask that you prepay for your dental services to reserve special appointment dates and/or times. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

□ Credit Card □ Cash □ Check □ Care Credit □ I would like to know more about my financial options

2. **DENTAL INSURANCE**…We want to help you maximize your insurance benefits. Please remember, dental insurance does not always cover the cost of your treatment as anticipated. While dental/medical costs have increased exponentially in the past 10 years, dental insurance benefits have remained relatively unchanged over the past 40 years. We do not allow insurance companies to dictate the course of treatment for our patients. Rest assured that we will recommend a treatment plan that is appropriate for your diagnosis regardless of what your insurance might or might not reimburse.

We are more than happy to request that your insurance benefits be sent directly to our office with your consent and if your plan offers this service. **Unfortunately, there are a few instances in which we cannot accept assignment of benefit. Some carriers will not send payment to the provider, even when we request that they do so. Delta Dental is one such. In this instance, we ask that you pay in full for services at which time we will handle the paperwork to see that you receive your direct reimbursement from your insurance carrier in a prompt manner. There are also insurance plans that are set up to reimburse on a "fee schedule", rendering estimates of coverage impossible. Finally, COBRA insurance, which is month to month insurance, pays benefits totally dependent upon receiving a premium by a set date. In these three instances, we ask that you pay in full for services at which time we will handle the paperwork to see that you receive direct reimbursement from your carrier in a prompt manner.**

Many insurance plans have frequency limitations, alternate benefit clauses, and other exclusions that ***may limit your coverage***. Ultimately, the patient is financially responsible for treatment costs. As a courtesy, we will attempt to obtain an *estimate* of your dental insurance assistance prior to services being rendered. If insurance does not pay as anticipated, our financial policy requires that the remaining balance be paid in full within 25 days of the final billing date. In addition, any insurance claim aged over 60 days that has not been paid or denied by the insurance carrier will become the patient's responsibility.

3. **ADDITIONAL ACCOUNT CHARGES**…We reserve the right to add a service charge to overdue accounts. The service charge will be a minimum of $5.00 and a maximum of $25.00 each month. A charge of $25 will be applied to all returned checks. We require that returned checks and fees be cleared by cash, certified funds, or credit card.

4. **DIVORCED PARENTS and THIRD PARTY BILLING**…It is the policy of this office that the parent/guardian accompanying the child to the visit be held responsible for treatment consents and all charges incurred; regardless of insurance, divorce decrees, or financial situations. We do not bill to any other third parties and we do not accept assignment of benefits from secondary insurance.

By signing below, I acknowledge that I understand and agree to Dr William Ralstin's financial policies. Even if I do not currently have dental insurance, I understand that the "Dental Insurance" section applies to me should I obtain dental insurance in the future. I will promptly notify the business office with any changes in my phone numbers, mailing address, and dental insurance coverage and/or eligibility status. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

X_____

Signature of □ Patient or □ Parent/Guardian Date

PATIENT CONSENT TO TREATMENT

In reading and signing this form it is understood that ENGLISH is the language that I understand and use to communicate.

PREVENTATIVE CARE: I understand that the long term success of treatment and status of my oral condition depends on my efforts at maintaining proper oral hygiene (i.e. brushing and flossing) and my diligence with regular recall visits. I further understand that failure to abide by recare recommendations set by William Ralstin, DDS, PC will negate any guarantee that may exist on restorative and/or prosthetic services provided by the dentists.

PEDODONTICS (CHILD DENTISTRY) if applicable: I understand that the following procedures are routinely used at this facility, as well as being accepted procedures in the dental profession.
A. POSITIVE REINFORCEMENT - Rewarding the child who portrays desirable behavior by use of compliments, praise, a pat or hug, and/or token objects or toys.
B. VOICE CONTROL - The attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice.
C. PHYSICAL RESTRAINT - Restraining the child's disruptive movements by holding down their hands, upper body, head, and/or legs by use of the dentist's or assistant's hand or arm.
D. NITROUS OXIDE AND/OR ORAL SEDATION - Nitrous oxide is a mild gas that is mixed with oxygen, and is used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedations are medications administered to children to help them relax. With their use, the parent/or guardian must understand that the child should not eat or drink for a period of eight hours prior to the sedation appointment. The parent/guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day.

LOCAL ANESTHETIC: I understand that with the use of an injection, used to numb the tooth for dental procedures, the possibility exists that I may inadvertently bite my lip causing possible injury. I understand the need to return to the office, for evaluation, if swelling and/or pain does not go away after a sufficient period of time.

I UNDERSTAND THAT NO GUARANTEE OR ASSURANCE HAS BEEN GIVEN THAT ANY PROPOSED DIAGNOSTIC, PREVENTATIVE, AND/OR PERIODONTAL TREATMENT WILL BE CURATIVE AND/OR SUCCESSFUL TO MY COMPLETE SATISFACTION. I AGREE TO COOPERATE COMPLETELY WITH THE RECOMMENDATIONS OF THE DOCTOR WHILE I AM UNDER HIS/HER CARE, REALIZING THAT ANY LACK OF SAME COULD RESULT IN LESS THAN OPTIMUM RESULTS. **(Initial Here)**_____

I CERTIFY THAT I HAVE HAD AN OPPORTUNITY TO READ AND FULLY UNDERSTAND THE TERMS AND WORDS WITHIN THIS CONSENT, AND AGREE TO THE OPERATION AND EXPLANATION REFERRED TO OR MADE. I HAVE BEEN ENCOURAGED TO ASK QUESTIONS, AND HAVE HAD THEM ANSWERED TO MY SATISFACTION. **(Initial Here)**_____

I UNDERSTAND THAT THIS FACILITY PROVIDES DENTAL CARE SERVICES WITHOUT DISCRIMINATION BASED ON RACE, RELIGION, COLOR, NATIONAL ORIGIN, SEX, SEXUAL ORIENTATION, PHYSICAL OR MENTAL DISABILITY, AGE OR MARITAL STATUS AND PROTECTS THE PRIVACY OF EACH OF ITS PATIENTS. **(Initial Here)**_____

I HAVE BEEN OFFERED AND/OR GIVEN A COPY OF THIS OFFICES PRIVACY PRACTICES FOR THE PROTECTION OF MY PERSONAL INFORMATION IN ACCORDANCE WITH GOVERNMENT HIPAA REGULATIONS. **(Initial Here)**_____

Signature:_____ **Date:**_____
Relationship to Patient:_____

IN FURTHER CONSIDERATION FOR THIS, DOCTOR AGREES TO THE SAME STIPULATIONS.

Patient Consent Form

William H. Ralstin, DDS. PA
2941 Oak Park Cir. Suite 100
Fort Worth, TX 76109
817-926-8700

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient:_____

Date:_____