Jacob J Ridl D.D.S.

Patient's Name Last	First	Middle				Date of Birth	Sex
Patient's Address Street	Apt.#	City	State	Zip		Home Phone	
Email		Cell Phone			SSN		
Person Responsible For Account Last	First	Middle					
Address Street	Apt.#	City	State	Zip		Home Phone	
Marital Status M ❑ S ❑ D ❑ W ❑	Employer				Occupation		
Work Address Street	City	State	Zip		Work Phone		
Spouse Name Last	First	Middle		Spouse Employer	Occupation		
Work Address Street	City	State	Zip		Work Phone		
Emergency Person We Can Contact (Other Than Your Family Home) Name	Work Phone	Home Phone					
Whom Can We Thank For Referring You To Our Office?							

INSURANCE INFORMATION

Insurance Coverage Yes ❑ No ❑	Insurance Company Name	Insurance Address	
Subscriber's Name	Patient's Relationship To Subscriber Self ❑ Spouse ❑ Dependent ❑	Subscriber's DOB	Subscriber's SSN
Group/Program Number	Employer	Employer Address	
Secondary Coverage Yes ❑ No ❑	Insurance Company Name	Insurance Address	
Subscriber's Name	Patient's Relationship To Subscriber Self ❑ Spouse ❑ Dependent ❑	Subscriber's DOB	Subscriber's SSN
Group/Program Number	Employer	Employer Address	

Assignment & Release:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office I am obligated to pay said office in accordance with its credits terms and policy.

I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature _____ Date_____

JACOB J. RIDL, D.D.S.

NAME: _____ NICKNAME:_____ Date of Birth_____

ADDRESS: _____ CITY: _____ STATE/ZIP: _____

PHONE #'s: HOME _____ WORK _____ CELL _____

E-MAIL: _____ EMERGENCY CONTACT: _____

MEDICAL HISTORY

IMPORTANT—Please read the following carefully before completing the Medical History

Many medical procedures and drugs which you are taking can have a direct bearing on the dental treatment provided in our office. To protect your health, we ask you to be as thorough as possible when answering the following questions. All information is kept completely confidential.

YES	NO		YES	NO		YES	NO	
☐	☐	Arthritis	☐	☐	Lung Disease/COPD	☐	☐	Frequent headaches
☐	☐	Rheumatic fever	☐	☐	Chronic Sinus trouble	☐	☐	Cold sore/Herpes
☐	☐	Rheumatic Heart disease	☐	☐	Tuberculosis	☐	☐	Blood disease
☐	☐	Heart Murmur/MVP	☐	☐	Asthma	☐	☐	Blood transfusion
☐	☐	Heart Valve Replacement	☐	☐	Shortness of breath	☐	☐	Prolonged Bleeding
☐	☐	Artificial Prosthesis	☐	☐	Hepatitis, Type _____	☐	☐	Epilepsy
		ie heart valve, joints	☐	☐	Liver Disease/Jaundice	☐	☐	Fainting Tendency
☐	☐	High Blood Pressure	☐	☐	Cancer or Tumor	☐	☐	Glaucoma
☐	☐	Arterial Stent	☐	☐	Diabetes	☐	☐	Autoimmune disease
☐	☐	Heart Catheterization	☐	☐	Kidney disease	☐	☐	Organ Transplant
☐	☐	Stroke	☐	☐	Anemia	☐	☐	Chemotherapy
☐	☐	Pacemaker	☐	☐	HIV/AIDS	☐	☐	Mental disorders
☐	☐	Chest pain/Heart attack	☐	☐	Sexually Transmitted diseases	☐	☐	Diverticulitis
☐	☐	Internal Automatic Defibrillator				☐	☐	Thyroid disease

Hospitalization for illness or injury _____

_____

List any medications you are taking including both prescription AND non prescription drugs

_____

_____

Are you allergic to or suffer any ill effects from:

☐ Penicillin ☐ Codeine ☐ Dental Anesthetic
☐ Aspirin/NSAIDS ☐ Household Bleach ☐ Latex
☐ Sulfa Drugs ☐ Sulfites (i.e. red wine) ☐ Other _____

FOR OFFICIAL USE ONLY

BP _____

WOMEN ONLY: Are you pregnant? _____ How many months? _____ Are you breast feeding? _____

Is there anything you would like to change or discuss about your teeth or smile? _____

_____

The above information is true to the best of my knowledge.

_____ Date _____

Patient or parent/guardian signature

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of the Statement of Privacy Practices for the office of Dr. Jacob J. Ridl, D.D.S. 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 the office with respect to my protected health information.
The Statement of Privacy Practices is also posted in the facility.
Dr. Jacob J.Ridl, D.D.S. 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 herby specifically authorize disclosure of my protected health care information to the persons below.	
ANY MEMBER OF MY IMMEDIATE FAMILY	YES__NO____
SPOUSE ONLY	YES__NO____
OTHER *(Please Specify)*	YES__NO____

SIGNATURE OR NAME OF PATIENT **DATE**

SIGNATURE OF PARENT OR CAREGIVER

OFFICE USE ONLY BELOW THIS LINE

Unable to Sign _____
Reason for Denial _____
Reason not Given _____
Other: _____