RANSON & RANSON
FAMILY DENTAL PRACTICE
320 E. Jackson St. Morton, IL
309-263-2021

Patient Registration

Last Name_____ First Name_____ MI_____ Date of Birth_____ Age____

Sex M or F Soc. Sec. # _____ Please circle one: Single Married Separated Widow

Mailing Address _____ City_____ State_____ Zip Code_____

Email_____ Home Phone ( )_____ Cell Phone ( )_____

Work Phone ( )_____Occupation _____

Are you a full time student? Yes or No If Patient is a minor: Mother's DOB _____ Father's DOB_____

Name of Parent_____ Parent Soc. Sec. # _____

Parent Employer _____ Parent Phone ( )_____

Person Responsible for Account _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone # ( )_____

If you are filling this form out on behalf of another person, what is your relationship to the person? _____

Name _____ Relationship _____

Reason for today's visit? _____

How did you hear about us? _____

Dental Insurance Information (Primary Carrier)

Insured's Name_____

Insured's Employer _____

Insured's DOB_____

Insurance Co. _____

Insurance co. Address _____

Insurance Phone # _____

Group # _____Local # _____

Dental Insurance Information (Secondary Carrier)

Insured's Name_____

Insured's Employer _____

Insured's DOB_____

Insurance Co. _____

Insurance co. Address _____

Insurance Phone # _____

Group # _____ Local # _____

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What would you like to change about your smile? Circle all that apply

Bite Chipped Teeth Spaces Crowding Smile Makeover Missing Teeth Whiter Teeth

Please share the following dates:

Your last cleaning _____/_____ Your last oral cancer screening _____/_____ Your last complete X-rays _____/_____

What is the most important thing to you about your future smile and dental health?_____
_____
What is the most important thing to you about your dental visit today?_____
_____
Why did you leave your previous dentist?_____
_____
Name of your previous dentist _____

Dental History

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

Dental History Cont. Please circle any of the following conditions that apply to you

Function

Grinding/Clenching
Headaches
Jaw joint pain (TMJ)
Jaw joint clicking/popping (TMJ)
Bad bite
Speech Impediment
Mouth Breathing
Sore Muscles (neck/shoulders)
Difficulty opening or closing
Difficulty Chewing on either side

Social

Tobacco
How much_____ How Long_____
Alcohol Frequency_____
Drugs Frequency _____

Habits

Thumb sucking
Nail-biting
Cheek/Lip biting
Chewing on ice
Chewing on foreign object

Sleep Pattern or Conditions

Sleep Apnea
Snoring
Daytime Drowsiness

Pain/Discomfort

Sensitivity (hot, cold, sweets)
Pressure
Broken teeth/filling
Worn teeth
Dry Mouth

Periodontal (Gum) Health

Bleeding, Swollen, Irritated gums
Bad Breath
Previous Perio/gum disease

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Medical History- Please circle your responses to indicate if you have or have had any of the following

Cancer	**Endocrinology**	**Musculoskeletal**	**Respiratory**	**Medical Allergies**
Type_____	Diabetes	Arthritis	Asthma	Antibiotic
Chemotherapy	Hepatitis A/B/C	Artificial Joints	Emphysema	(Penicillin/Amoxicillin/ Clindamycin)
Radiation Therapy	Jaundice	Jaw Joint Pain	Respiratory Problems	Opioids
Cardiovascular	Kidney Disease	Rheumatoid Arthritis	Sinus Problems	(Percocet, Oxycodone, Tylenol 3)
Angina (Chest Pain)	Liver Disease	**Neurological**	Sleep Apnea	Latex
Artificial Heart Valve	Thyroid Disease	Anxiety	Tuberculosis	Local Anesthetics
Heart Conditions	**Gastrointestinal**	Depression	**Viral Infections**	NSAIDs
Heart Surgery	Ulcers (Stomach)	Dizziness	AIDS	Other Allergies
High/Low Blood Pressure		Drug/Alcohol Addiction	HIV Positive	_____
Mitral Valve Prolapse	**Hematologic/Lymphatic**	Fainting	HPV	_____
Pacemaker	Anemia	Seizures	**Women**	
Rheumatic Fever	Blood Disorders	Psychiatric Illness	Currently Pregnant	
Scarlet Fever	Bruise easily		Nursing	
Stroke	Excessive Bleeding			

Medical History Cont.

Are you under the care of a physician? Y or N If Yes, Please explain_____
_____
Physician Name_____Address_____ Phone( )_____
Have you have a serious Illness, Operation, or hospitalization in the past 5 years? Y or N, if yes please explain_____
_____
Are you taking or have you recently taken any prescription or over the counter medication(s) Y or N If yes, Please list all and why, including vitamins, natural or herbal supplements and.pr dietary supplements_____
_____
Have you ever in the past, or are you now currently taking any medications for Osteopenia/Osteoporosis or Bone Disease?
If so, Please list medications:_____
Have you ever had surgery? If so, What type:_____
_____
Consent:

The undersigned hereby authorizes Doctor(s) to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor(s) to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor(s) to perform any and all forms of treatment, medication and therapy that may be indicated, I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions. I authorize Ranson Dental to furnish any consulting physician or insurance company and its representative, any information or copies of all hospital, medical records, consultation and prescriptions relating to illness or injury. A copy of this authorization shall be effective and valid. This authorization may be revoked at any time.

_____
Signature of Patient/Legal guardian Print Name Date Dentist Signature

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received and have been presented with opportunity to review the office of Ranson Family Dental, Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of any future revised Notices.

_____ _____

Patient/Parent/Spouse/Legal Guardian Date

Reason that Notice was not accepted or patient/representative did not acknowledge receipt:

_____Patient indicates received on prior visit _____ Patient declined to sign

_____ Patient/Representative initials if declined _____ Employee initials (if patient/representative did not accept

Financial Agreement

I hereby assume full responsibility for and agree to pay all cost, charges, and expenses incurred by the patient to Ranson Family Dental. I understand and agree that this understanding constitutes a direct primary and personally undertaking by me and is not conditioned or contingent upon payment of any such cost, charges or expenses by any third party. As assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of Provider's rights to require payment directly from the undersigned. The Provider expressly resources it's right to require such payment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

PLEASE NOTE: Return checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistants; you will be responsible for any collection and/or legal charges up to 33%/55%.

Do you have insurance?

- ☐ We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company.
- ☐ As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- ☐ We ask that you sign this form and /or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

We thank you for choosing our office to serve your dental needs and welcome any questions you may have concerning your care or our financial policy.

_____ _____

Signature of Patient/Parent/Legal Guardian Date

*** We kindly request a 24 hour notice for any changes to your scheduled appointment. We reserve the right to charge $25.00 for any appointments Missed or cancelled without a 24 hour notice.**