Patient Profile

RICHTER dental

Patient Name _____ Date _____

☐ Male ☐ Female Social Security Number _____

☐ Married ☐ Single ☐ Minor Birthdate _____

Street Address _____

City/State/Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address _____

Employer _____

Employer Street Address _____

Employer City/State/Zip _____

If Full Time Student, School Name _____ Grade _____

Person Responsible for Account

☐ Patient ☐ Spouse ☐ Mother ☐ Father ☐ Guardian

List any member of your family that has been treated at our office: _____

Preferred Pharmacy _____

Phone Number of Pharmacy _____

INSURANCE INFORMATION

Adults complete Primary Insured. **Dual Converage** complete Secondary Insured. **Minor child** may need to complete both Primary and Secondary Insured.

Primary Insured / *If no insurance, complete for responsible party*

Last Name _____

First Name _____ M. Initial _____

Street Address _____

City/State/Zip _____

Phone _____ Birthdate _____

Relationship to Patient _____

Employer _____

Dental Ins. Company _____

Subscriber# _____ Group# _____

Member ID#/SS# _____

Secondary Insured

Last Name _____

First Name _____ M. Initial _____

Street Address _____

City/State/Zip _____

Phone _____ Birthdate _____

Relationship to Patient _____

Employer _____

Dental Ins. Company _____

Subscriber# _____ Group# _____

Member ID#/SS# _____

EMERGENCY CONTACT

Name _____

Street Address _____

City/State/Zip _____

Phone _____

METHOD OF PAYMENT

☐ Responsible party currently has an account with Richter Dental

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment

☐ VISA ☐ MC ☐ OTHER _____

Credit card# _____

Exp. Date _____

☐ I wish to discuss Richter Dental's Financial Policy

AUTHORIZATION

I hereby authorize payment directly to Richter Dental of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Richter Dental to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information in this document are correct to the best of my knowledge. I grant the right to Richter Dental to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

Signature of Responsible Party _____

Date _____

State Driver's License _____

Service Charge

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. 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.

How Did You Hear About Us?

RICHTER dental

Patient Name _____ Date _____

☐ Another Patient
Name: _____ Email or Address: _____

☐ Referring Doctor
Name: _____ Email or Address: _____

☐ Referral Campaign Postcard

☐ Richter Dental Website

☐ Facebook

☐ Richter Dental Mailer

☐ Google

☐ Yelp

☐ Yellow Pages

☐ Newspaper

Other: _____

Dental History

RICHTER dental

Patient Name _____ Date _____

Primary reason for this dental appointment:

- ☐ Examination
- ☐ Emergency
- ☐ Consultation

DENTAL HISTORY

☐ Yes ☐ No Do you have a specific dental problem?
If yes, describe _____

☐ Yes ☐ No Do you have dental examinations on a routine basis?
Last visit _____

☐ Yes ☐ No Do you brush and floss on a routine basis?
If yes, how often? _____

☐ Yes ☐ No Do you think you have active decay or gum disease?

☐ Yes ☐ No Do your gums ever bleed?
If yes, describe _____

☐ Yes ☐ No Any sores or growths in your mouth?
If yes, describe _____

☐ Yes ☐ No Does food catch between your teeth?

☐ Yes ☐ No Do you have any loose teeth?

☐ Yes ☐ No Do you want to keep your remaining teeth?

☐ Yes ☐ No Do you ever have clicking, popping, or discomfort in the jaw?

☐ Yes ☐ No Do you clench or grind?

☐ Yes ☐ No Do you smoke or chew?

☐ Yes ☐ No Have your past experiences in dental offices always been positive?

☐ Yes ☐ No Do you like your smile?
Why? _____

Name of previous dentist (optional) _____

Date of last full mouth x-rays _____

UPDATES

I have read my DENTAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions _____ Patient Signature _____

Date _____ Exceptions _____ Patient Signature _____

Date _____ Exceptions _____ Patient Signature _____

Date _____ Exceptions _____ Patient Signature _____

Date _____ Exceptions _____ Patient Signature _____

Medical History

RICHTER dental

Patient Name _____ Date _____

MEDICAL HISTORY

☐ Yes ☐ No Are you under a physician's care now?
Why? _____
Who? _____
Physician's Phone _____

☐ Yes ☐ No Have you ever been hospitalized or had a major operation?
If yes, describe _____

☐ Yes ☐ No Have you ever had a serious injury to your head or neck?
If yes, describe _____

☐ Yes ☐ No Are you taking any medications, aspirin, vitamins, herbals, pills or drugs?
If yes, describe _____

☐ Yes ☐ No Are you on a special diet?
If yes, describe _____

☐ Yes ☐ No Are you allergic to any medications or substances?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Milk
- ☐ Acrylic
- ☐ Metal
- ☐ Latex rubber
- ☐ Other _____

Women (please check):

- ☐ Pregnant/trying to get pregnant
- ☐ Nursing
- ☐ Taking oral contraceptives

If yes, list _____

Have you ever taken any of the following medications?

- ☐ Fen-Phen (*If yes, please call prior to your appointment…premedication or changes in medication may be required.)*
- ☐ Bisphophonates
- ☐ Aredia I.V.
- ☐ Reclast I.V.
- ☐ Zometa I.V.
- ☐ Fosamax, Actonel, Boniva
- ☐ Protease Inhibitor

☐ Yes ☐ No Do you wish to talk to the dentist privately about any problem?
If yes, describe _____

Medical History Continued

RICHTER dental

Patient Name _____ Date _____

Do you now have or have you ever had any of the following?

**If yes, please call prior to your appointment…premedication or changes in medication may be required.)*

- ☐ Heart Disease/Surgery*
- ☐ Heart Murmur or Defect*
- ☐ Irregular Heart Beat
- ☐ Angina/Chest Pain
- ☐ Heart Attack/Failure
- ☐ Congenital Heart Disorder*
- ☐ Mitral Valve Prolapse*
- ☐ Scarlet Fever
- ☐ Rheumatic Fever*
- ☐ Artificial Heart Valve*
- ☐ Heart Pace Maker*
- ☐ Pulmonary Shunt*
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bacterial Endocarditis*
- ☐ Unexplained Fever
- ☐ Bruise Easily/Blood Disease
- ☐ Anemia
- ☐ Coronary Stent*
- ☐ Excessive Bleeding
- ☐ Sickle Cell Disease
- ☐ Hemophilia
- ☐ Methemoglobinemia
- ☐ Lukemia
- ☐ Recent Blood Transfusion
- ☐ Swelling of Limbs
- ☐ Lung Disease
- ☐ Breathing Problem
- ☐ Shortness of Breath
- ☐ Frequent Cough
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Asthma
- ☐ Bloody Sputum
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Cancer
- ☐ X-Ray (Radiation)
- ☐ Chemotherapy
- ☐ Osteoporosis
- ☐ Osteonecrosis of Jaw
- ☐ Stomach/Intestinal Disease
- ☐ Ulcers
- ☐ Recent Weight Loss
- ☐ Frequent Diarrhea
- ☐ Diabetes
- ☐ Excessive Thirst
- ☐ Hypoglycemia
- ☐ Liver Disease
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B or C
- ☐ Night Sweats
- ☐ Yellow Jaundice
- ☐ Kidney Problems
- ☐ Renal Dialysis
- ☐ Thyroid Disease
- ☐ Parathyroid Disease
- ☐ Arthritis/Gout
- ☐ Rheumatism
- ☐ Pain in Jaw Joints
- ☐ Cortisone Medicine
- ☐ Artificial Joint*
- ☐ AIDS
- ☐ HIV Positive
- ☐ Genital Herpes
- ☐ Sexually Transmitted Disease
- ☐ Drug Addiction
- ☐ Alcoholism
- ☐ Tattoos/Body Piercing
- ☐ Sleep Apnea
- ☐ Cold Sores
- ☐ Fever Blisters
- ☐ Herpes
- ☐ Stroke
- ☐ Convulsions
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Tumors or Growths
- ☐ Nervousness
- ☐ Psychiatric Care
- ☐ Alzheimer's Disease
- ☐ Allergies(Medicines)
- ☐ Allergies(Pollen/Dust)
- ☐ Hives or Rash
- ☐ Cochlear Implants

Have you ever had any other serious illness not checked above?
If yes, describe _____

_____

UPDATES

I have read my MEDICAL HISTORY dated_____ and confirm that it adequately states past and present conditions.

Date _____ Exceptions _____ Patient Signature _____
Date _____ Exceptions _____ Patient Signature _____
Date _____ Exceptions _____ Patient Signature _____
Date _____ Exceptions _____ Patient Signature _____
Date _____ Exceptions _____ Patient Signature _____

REVIEWED BY DOCTOR Date_____ BP _____ Pulse _____

History Review/Significant Findings _____

_____

_____

Sleep Apnea Survey

Patient Name _____ Date _____

Height _____ inches Weight _____ lb Age _____

Collar size of shirt: S,M,L,XL, or _____ inches

Neck circumference _____ cm (this will be measured by staff)

High risk of Obstructive Sleep Apnea= answering yes to 3 or more items
Low risk of Obstructive Sleep Apnea= answering yes to less than 3 items

1. Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
   ☐ Yes ☐ No
2. Do you often feel tired, fatigued, or sleepy during daytime?
   ☐ Yes ☐ No
3. Has anyone observed you stop breathing during your sleep?
   ☐ Yes ☐ No
4. Do you have, or are you being treated for high blood pressure?
   ☐ Yes ☐ No
5. Is your BMI more than 35?
   ☐ Yes ☐ No
6. Are you over 50 years old?
   ☐ Yes ☐ No
7. Neck circumference greater than 40cm?
   ☐ Yes ☐ No

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not been in the following situations recently, try to consider how they would have affected you. It is important that you answer each question as best you can.

Choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing (0-3)**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theatre or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in the traffic	0	1	2	3

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully. The privacy of your health information is important to us.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect ___/___/___, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us: Richter Dental, call 219.769.4600, email nrichter@richterdental.com, or mail 8750 Broadway, Suite D, Merrillville, Indiana 46410.

Uses and Disclosures of Health Information

We use and disclose health information about your treatment, payment, and healthcare operations. For example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner, and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person, to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of the health safety of others.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____ ,
Please Print Name

have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify) _____

_____

_____

_____

Financial Policy of Richter Dental

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

Patients with dental insurance

As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to all traditional, indemnity insurance plans, and PPO (Out of Network). We do not accept DMO or DPO plans (Dental Maintenance or Dental Provider Organizations). Under these plans, there is NO COVERAGE when treatment is rendered by a non-participating dentist. Please check your type of plan carefully.

Payments

We accept cash, check, VISA, MasterCard, and Discover. Outside financing is available upon request and approval. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide a complimentary benefits check. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. If you should need special payment arrangements, contact our office immediately to discuss your options. If a credit balance should result after insurance processes your claim, a refund will be issued.

Unpaid insurance claims

All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a refund will be issued.

Past-due accounts

If payment is not received by the due date printed on the statement, then your account is considered "past due". If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance, as well as a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients without dental insurance

Payment in full is expected at the time services are rendered. We accept cash, check, VISA, MasterCard, and Discover.

Please note that a fee of $75 will be assessed for cancelled appointments.

Richter dental reserves the right to update and make changes to the above stated office policies at any time without prior notification. By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental service rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient: _____

Photograph & Video Release Form

I hereby grant permission to _____ to the rights of my image, likeness and sound of my voice as recorded on audio or video tape without payment or any other consideration. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

I consent to being the subject of the media as described above, and authorize Dr. Richter to cause the same to be exhibited, as still photographs, video or other media. I release Dr. Richter and any associates from any and all claims for damages for libel, slander, invasion of privacy or any other claim based on use of the above described media.

Photographic, audio or video recordings may be used for the following purposes:

- Conference presentations
- Educational presentations or courses
- Informational presentations, brochures, booklets, etc.
- On-line educational courses educational videos
- Website, social media and other online use
- Posters, flyers and other in-office use

By signing this release I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the sessions listed on this document only.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name: _____

Street Address/P.O. Box: _____

City: _____

Prov/Postal Code/Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Signature: _____ Date: _____

If this release is obtained from a patient under the age of 18, then the signature of that patient's parent or legal guardian is also required.

Parent's Signature: _____ Date: _____