KEVIN L. RAGSDALE D.D.S.

PATIENT MEDICAL HISTORY

TO NEW PATIENTS: IT'S NICE TO GET ACQUAINTED. DATE ____________

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have any questions regarding your treatment, your appointments, or fees, please feel free to ask. Your kindness in furnishing the following information will be appreciated. Please remember that the answers to these questions are held in strict confidence. We are here to help you. Your dental and oral health is important to us. We desire to give you quality care and we believe in treating all our patients equally, All work is done by pre-arranged appointment. Please make your appointment carefully, as a great deal of time and preparation will be made for and prior to your appointment. If at any time there are changes in your address, phone number, or health history please let us know. NOTE: If patient is a minor, (under 18), write name and relationship of adult who will be responsible for payment.

Patient name ____________ FIRST ____________ MIDDLE ____________ LAST

Soc Sec. # ____________ Birthdate ____________ Sex: M F

Address ____________ STREET ____________ APARTMENT # ____________ CITY ____________ STATE ____________ ZIP P.O. Box ____________

Home Phone ____________ Cell Phone ____________ Email Address ____________

Work Phone ____________ Ext:______ Employer ____________ What Hours Or Shift ____________

Marital Status: S M D W If married, spouse's name ____________

Patient's Physician ____________ Driver's License # ____________ State ______

Is patient covered by Dental Insurance? .... ☐ yes ☐ no

Person responsible for payment ____________ Driver's License # ____________ State ______

Address ____________ P.O. Box ____________

Home Phone ____________ Work Phone ____________ Employer ____________

Relationship to patient ____________ Social Security # ____________

1. Are you under any medical treatment now? If so, for what? .... yes no
2. Have you had abnormal bleeding after cuts, surgery, or dental extractions? .... yes no
3. Are you now taking any drugs, medicine or pills? .... yes no

   If yes, please list ____________

   a. Have you taken any aspirin in the last 3 days? yes no. If yes, how often? ____________ how many? ______
4. Do you have, or have you ever had: (check any that applies)

☐ angina
☐ rheumatic fever
☐ rheumatic heart disease
☐ artificial joint replacement
☐ tuberculosis
☐ diabetes
☐ thyroid problem
☐ leukemia
☐ anemia
☐ heart murmur
☐ mitral valve prolapse
☐ lupus
☐ high blood pressure
☐ heart attack
☐ artificial heart valve or prosthesis
☐ AIDS
☐ hemophilia *(free bleeder)*
☐ By-Pass Surgery
☐ epilepsy *(fainting or seizures)*
☐ pacemaker
☐ kidney disease
☐ liver disease
☐ steroid therapy
☐ cancer: type ____________
☐ ulcer
☐ stroke
☐ hepatitis or yellow jaundice
☐ glaucoma
☐ venereal disease or syphilis

5. Are you allergic to, or have you ever reacted adversely to: (check any that applies)

☐ local anesthetic (such as novacaine)
☐ Keflex (or Cephalosporins)
☐ Penicillin (or other "Cillin")
☐ Codeine ☐ Hydrocodone ☐ Oxycodone
☐ Acetominophen (Tylenol)
☐ sulfa drugs
☐ Demerol
☐ Erythromycin
☐ aspirin
☐ Tetracycline
☐ sedatives, barbituates or sleeping pills
☐ other? ....
☐ Latex/Rubber

6. Women: Are you presently taking birth control pills? .... yes no

7. Is there any condition you feel your dentist should know about before undertaking dental treatment? If so, explain yes no

____

(form continued reverse side)

8. Women: Are you pregnant? .... yes no

Due Date: ______________ Doctor's Name ______________

Are you nursing? .... yes no

9. Are you an apprehensive patient? .... yes no

10. Have you ever had a problem with local anesthesia (such as novacaine) or an allergy or reaction to a local anesthetic? _____

REFERRAL: Please indicate how you heard about our office:

☐ Doctor/Dentist - Their name ______________ ☐ Yellow Pages

☐ Another Patient - Their name ______________ ☐ Other ______________

PAYMENT POLICY: In compliance with the Truth and Lending Law, here is our financial policy: It is customary to take care of fee at time service is rendered unless prior arrangements have been made. To assist you with this we accept VISA and MasterCard.

For our patients without dental insurance: any single treatment involving a single visit must be paid for at time of treatment. Any single treatment involving multiple visits may have the fee divided into the number of visits, beginning with ½ of the fee being paid at the start of treatment, with the balance to be paid for at delivery.

For our patients with dental insurance: be aware of your policy and its deductibles, exclusions, and yearly maximums. After you pay your policy's deductible we will accept assignment on that portion of your fee covered by insurance, but you are ultimately responsible for your balance. Any single treatment involving a single visit will require that you pay your portion, or estimated portion, at the time service is rendered. Any single treatment involving multiple visits will allow you to divide your portion, or estimated portion, into the number of visits beginning with ½ of your portion at the start of treatment. If a patient, or family, is covered by more than one policy we will gladly accept both assignments prior to the final balance, provided that both deductibles have been met. Be aware that in many cases the insurance company or companies will require a pre-treatment estimate prior to beginning treatment. We will make recommendations at that time concerning the beginning of treatment.

If Dental Insurance assignment is accepted, I authorize payment directly to Dr. Kevin L. Ragsdale of any group benefits otherwise payable to me and agree to the release of information relating to this claim.

Please fill in the following: Name of person who has primary dental insurance ______________

Date of birth of person who has primary dental insurance ______________

Employer & Dental Insurance Company ______________ Soc. Sec. # ______________

If applicable, fill in the name of person who has secondary dental insurance ______________

Employer & Dental Insurance Company ______________ Soc. Sec. # ______________

Work will not be delivered if there is a balance due prior to the delivery date.

We reserve the right to send statements to patients at our discretion based upon treatment and payment history. Multiple statements will have a $2.00 per month billing and processing fee added to the remaining balance if not paid in full within 30 days of treatment completion or delivery. This applies to patients with or without dental insurance.

Should this account be turned over for collection and/or legal collection the person(s) responsible for payment will be liable for any fees incurred in the process of collection.

Appointments are adhered to as much as possible; however, emergencies do arise as well as the unexpected.

Any patient who cancels an appointment the day before or the day of the appointment; or who fails to show for the appointment, will be charged for an office visit for each unkept appointment beginning with the third occurrence.

I certify that the medical and dental history information is correct to the best of my knowledge and that I have read and accept the above credit policy terms.

______________ ______________

Signature of Patient Date

(or Parent/Guardian if patient is a minor)