Kimberly A. Rice, D.D.S., PLC

529 N. Hewitt Road, Ypsilanti, MI 48197 / 734-434-3820

PATIENT REGISTRATION Name_____ Sex: ☐M ☐F

Name you would like us to call you _____ Pronouns _____ Gender _____

Email_____ Phone: Home_____Work _____Cell _____

Address _____ City _____State_____ Zip _____

Employer _____ Marital Status_____ Birth Date _____

Social Security #_____ Drivers License # _____

Whom may we thank for referring you _____

If over age 18, are you a full time student? ☐ Yes ☐ No

BILLING INFORMATION

Responsible Party_____ Relationship to Patient_____

Address (If Different)_____ City_____ State____ Zip_____

Phone: Home_____ Business_____

Social Security_____ Employer_____

PATIENTS WITH DENTAL INSURANCE

Insured's Name_____ Social Security No_____ Birth Date_____

Insurance Company_____ Group #_____

Employer_____ Business Phone_____

SECONDARY INSURANCE

Insured's Name_____ Social Security No_____ Birth Date_____

Insurance Company_____ Group #_____

Employer_____ Business Phone_____

I hereby authorize payment to Kimberly A. Rice, D.D.S., PLC of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Kimberly A. Rice, D.D.S., PLC to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge. Before any financial arrangements are made I authorize Kimberly A. Rice, D.D.S., PLC the right to obtain a credit report.

PATIENT'S SIGNATURE_____ **DATE**_____

OFFICE NOTE

DENTAL HISTORY

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) if you have had problems with any of the following:

☐ Bad breath	☐ Food collection between teeth	☐ Periodontal treatment	☐ Sensitivity to sweets
☐ Bleeding gums	☐ Grinding or clenching teeth	☐ Sensitivity to cold	☐ Sensitivity when biting
☐ Clicking or popping jaw	☐ Loose teeth or broken fillings	☐ Sensitivity to hot	☐ Sores or growths in mouth

How often to you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Are you currently under a physician's care? ☐ Yes ☐ No If yes, describe _____

Have you ever had any surgeries? ☐ Yes ☐ No If yes, give type & date _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (✓) if you have had any of the following:

☐ AIDS/HIV Positive	☐ Cough, persistent	☐ Hepatitis	☐ Rheumatic / Scarlet fever
☐ Anaphylaxis	☐ Cough up blood	☐ High blood pressure	☐ Shingles
☐ Anemia	☐ Diabetes	☐ Jaw pain	☐ Shortness of breath
☐ Arthritis, Rheumatism	☐ Epilepsy	☐ Kidney disease or malfunction	☐ Skin rash
☐ Artificial heart valves	☐ Fainting	☐ Liver disease	☐ Spina Bifida
☐ Artificial joints	☐ Food allergies	☐ Material allergies (latex, wool, metal, chemicals)	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Mitral valve prolapse	☐ Surgical implant
☐ Atopic (allergy prone)	☐ Headaches	☐ Nervous problems	☐ Swelling of feet or ankles
☐ Back problems	☐ Heart murmur	☐ Pacemaker / Heart surgery	☐ Thyroid disease or malfunction
☐ Blood disease	☐ Heart problems	☐ Psychiatric care	☐ Tobacco habit
☐ Cancer	Describe _____	☐ Rapid weight gain or loss	☐ Tonsillitis
☐ Chemical dependency	_____	☐ Radiation treatment	☐ Tuberculosis
☐ Chemotherapy	☐ Hemophilia / Abnormal bleeding	☐ Respiratory disease	☐ Ulcer / Colitis
☐ Circulatory problems	☐ Herpes		☐ Venereal disease
☐ Cortisone treatments			

List medications you are currently taking, if any:

_____

_____

List drug allergies, if any:

_____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on the form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.