Office Use Patient ID#_____

New Patient Registration Form

Welcome to *Ascot Aesthetic* Implants & Dentistry

Date: _____

Patient's Name_____ **SSN#**_____
Title (Please check one) **Mr.** □ **Mrs.** □ **Ms.** □ **Miss** □ **Dr.** □ **Rev.** □ Other □_____
Marital Status: (Please check one) **Single** □ **Married** □ **Divorced** □ **Widowed** □

Gender: Male □ Female □ **Date of Birth:** Month _____Day _____Year _____ Driver License#_____

Address_____**City**_____**State**_____**Zip Code**_____

Home#_____ **Cell#**_____ **Work#**_____

Email Address _____
Consent to receive emails, text, and/or Post Cards for appointment reminders:
Email: Yes □ No □ **Text Messages:** Yes □ No □ **Recall Post Cards:** Yes □ No □

Emergency Contact: _____**Relationship**_____**Phone**_____

Insurance: Yes □ or No □ **Self Pay:** Yes □ or No □ **** (If Self Pay skip to Patient Medical History) ****

Subscriber Information: Check One: Self____ Spouse____ Other_____

Relationship to Subscriber: Check One: Self___ Spouse___ Child ____ Other_____
Subscriber's Name_____ **DOB**_____**SSN#**_____

Address_____**City**_____**State**____ **Zip Code**_____

Employed By_____ **Employer's Address**_____

Home#_____ **Cell#**_____ **Work#**_____

************************Patient Medical History************************

Physician's Name_____

Date of last physical _____ Office Phone #_____ Office Fax # _____

1. Are you in general good health at this time? **Yes**□ **No**□

2. Are you under any medical treatment now? If so, for what condition(s)?_____
_____

3. Do you have a history of fainting or seizures?**Yes**□ **No**□ Have you had joint replacement surgery? **Yes** □ **No**
If Yes, when? _____
4. Have you had any major operations? If so, what? _____

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5. Have you ever had any abnormal bleeding, or required a blood transfusion? **Yes** □ **No** □
6. Do you have a history of drug or alcohol abuse? **Yes** □ **No** □
7. Are you under Pain Management Program? **Yes** □ **No** □ If Yes, Name of Provider_____
Provider's Phone#_____
8. Do you use tobacco products? **Yes** □ **No** □
Type of product_____ How much daily _____ For how long? _____
9. Have you ever had one of the following:

	Yes	or	**No**
Prosthetic Cardiac Valve (including palliative shunts & conduits)	□		□
Cardiac Transplant	□		□
Previous Infective Endocarditis	□		□
Orthopedic surgery with joint prosthetic replacement?	□		□

10. Has a physician ever informed you that you have: **Please answer Yes or No**

Cardiovascular Disease _____	Stroke _____	High Blood Pressure _____
Neurological Disease _____	Diabetes _____	Growths or Tumors _____
Thyroid Problems _____	Sinus Problems _____	Asthma _____
Liver Disease _____	Kidney Disease _____	Hepatitis _____
Stomach or Intestinal Disease_____	Tuberculosis _____	Emotional Problems _____
Aids of HIV Infections _____	Sexually Transmitted Disease _____	

11. Do you have any known Drug Allergies **Yes** □ **No** □
or are you allergic to, or have you ever reacted adversely to: **If yes, what type of reaction (rash, SOB,)**

Local Anesthetic (such as Novocain)? _____	Aspirin of Codeine? _____
Penicillin, sulfa drugs, or other antibiotics? _____	Barbiturates, sedatives or sleeping pills? _____
Latex _____Other _____	

12. Have you been diagnosed with Sleep Apnea? **Yes** □ **No** □ Do you use a CPAP machine or any other oral mandibular advancement device? **Yes** □ **No** □

13. Please list any medications you are **currently** taking. _____

_____

Pharmacy: _____Location: _____Phone_____

14. Are there any medical or dental conditions you feel your dentist should know before starting your dental treatment? If so, please explain_____

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15. Are you Pregnant? **Yes** □ **No** □ Nursing? **Yes** □ **No** □ Taking Oral Contraceptives? **Yes** □ **No** □

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****Note: While being a patient in our practice, Dr. Ruff may find it necessary to prescribe an antibiotic to fight off an existing dental infection or to prevent possible infection during a dental procedure. If you are taking oral contraceptives (birth control pills), additional contraceptive measures are recommended while taking antibiotics and for a period of time following the course of antibiotic therapy. Please follow the instructions that were enclosed with your BCP pack or call your physician or pharmacist for specific instructions. ****

16. Have you had sedation for past dental care? If so, what type_____
Nitrous Oxide □ Oral Sedation □ Intravenous □

17. Are you interested in sedation for future dental treatment? _____

18. Do you have difficulty with strong gag reflex? **Yes** □ **No** □

19. I will allow Dr. Angela Ruff to use anonymous before/after photographs for use of lecture, publications and/or educational purposes. I understand my identity will remain concealed. **Yes** □ **No** □

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ **Date**_____
(Signature of Patient and/or Legal Guardian)

Medical History Update:

Date	Comments	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Ascot Aesthetic Implants Dentistry

Dental History

(Rev 11/2/10)

REFERRAL

Whom may we thank for referring you? _____

Date and reason for last dental visit _____

_____

Name of previous dentist _____

Reason for changing _____

Describe your current dental problems _____

OFFICE USE

Thank You Note Y/N

APPREHENSION

What did you like least about any of your previous dental experiences? _____

What did you like most about any of your previous dental experiences? _____

Have you ever received "laughing gas" in a dental office? _____

Have you ever received any other kind of sedation for dental treatment? _____

Would you like sedation for your dental visit?

CASEY:

Nitrous Oxide / Sedation

Patient Prefers:

Nitrous Oxide Y/N

Oral sedation Y/N

IV Sedation Y/N

TEETH PROBLEMS

Are any of your teeth sensitive to hot, cold, sweets, or pressure? _____

_____

How long have you suffered with this sensitivity? _____

CASEY:

RCT / EXT

GUM PROBLEMS

When is the last time you had a dental cleaning? _____

Do your gums bleed when you brush or floss? _____

Do you feel that you may have a problem with bad breath? _____

CASEY:

Perio DX / S&RP

YOUR SMILE

Would you like to have whiter teeth? _____

Would you be interested in "straightening" your teeth? _____

Do you have any spaces between your teeth that you would like closed? _____

Would you like to know how your smile could be improved? _____

CASEY:

Bleaching / Veneers

Crowns / White Fillings

HEADACHES AND FACIAL PAIN

Do you ever have more than one headache per month? _____

Do either your jaw or face muscles get tired or sore after chewing, sleeping, stress, etc? _____

_____

Does your jaw pop or crack? _____

Have you noticed your teeth becoming shorter? _____

Would you like to know what could be done conservatively to prevent future damage to your teeth and jaw? _____

CASEY:

Bruxism

TMJ Evaluation Y / N

MISSING TEETH

How old is your existing denture and/or partial? _____

Would you be interested in hearing options about replacing missing teeth? _____

If so, would you prefer the replacement teeth to be "cemented" in place; or have the option of removing them before bed? _____

CASEY:

Bridges / Implants

Partials / Dentures

Ascot Aesthetic Implants and Dentistry

Dr. Angela C. Ruff

Ascot Plaza * 5815 Ramsey Street, Fayetteville, NC 28311 Phone 910-630-6199 Fax 910-630-3647

Financial Policy

In compliance with the truth and lending law, this is our financial policy:

It is customary to take care of your fee at the time service is scheduled. To assist you with this we accept cash, checks, Visa, MasterCard, Discover, American Express, Care Credit and Citi Health Cards. If you have dental insurance, we will be happy to send for a pre-estimate as well as mail necessary documentation (i.e. x-rays, photos, etc.) when filing your dental claims. However, it must be understood that you will be responsible for any portion, including finance charges, not paid by insurance within 60 days after filing your claim.

Confirmation Policy

Your appointment with us is very important. The appointment time and length scheduled is made exclusively for you. To avoid broken appointments, we ask that you confirm your scheduled appointments with our office. You may call at anytime, voicemail available after hours, or use our new *Smile Reminder* system. With *Smile Reminder* we can send text messages and/or emails and you may respond at your convenience.

Most cleaning appointments are scheduled six months in advance. As a courtesy reminder post cards are mailed approximately three weeks prior to your appointment and phone, text and email reminders are made 1-2 weeks prior to your appointment. We ask that you confirm your scheduled appointment with our office at least one week prior to your appointment date. If we do not receive a positive confirmation from you, your appointment time may be offered to another patient.

Cancellation Policy

Appointments scheduled in our office are specifically reserved for each patient. We are able to provide you with individualized, quality care with the least amount of waiting time by not double-booking each appointment. Therefore, if you find it necessary to cancel or reschedule an appointment, we ask that you please give us a 48-hour notice (during business hours), so that we are able to offer this time to another patient. If you fail to show for a scheduled appointment, or if you do not give us the required 48 business hour notice when canceling, your account will be charged a broken appointment fee. The amount charged may vary depending upon the length of the scheduled appointment.

I have read and understand your financial, confirmation and cancellation policies.

I hereby authorize any insurance coverage to be paid directly to Angela C. Ruff, D.D.S., P.A for services rendered.

_____ _____ Legal

Signature of Patient or Parent and/or Guardian Date

Ascot Aesthetic
IMPLANTS & DENTISTRY

Ascot Plaza • 5815 Ramsey Street
Fayetteville, NC 28311
Phone: 910.630.6199
Fax: 910.630.3647
Dr. Angela C. Ruff

ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name _____ Date _____

Signature _____

Relationship to Patient _____

Dependent family members also covered by this acknowledgment: _____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our *Notice of Privacy Practices* due to the following reason:

○ The patient refused to sign ○ Communication barriers

○ Emergency situation ○ Other

Ascot Aesthetic Implants and Dentistry

Dr. Angela C. Ruff
Ascot Plaza 5815 Ramsey Street, Fayetteville, NC 28311*
Phone 910-630-6199 Fax 910-630-3647

Consent for Release of Dental Records

I do hereby consent to and authorize *Ascot Aesthetic Implants and Dentistry* to **(Circle one)** Release/Acquire information concerning dental records and x-rays, including current and previous dental records from other practices and practitioners, hospitals and/or clinics.

Please list the name/DOB of the patient(s) of which records are to be released:	
Name:	DOB:
Name:	DOB:
Name:	DOB:
Name**:**	DOB:
The records are being released to:	
Name:	
Email:	
Phone/Fax#	

I release Ascot Aesthetic Implants and Dentistry practitioners from any responsibility for my future dental health.

Signature of Patient/Guardian or Responsible Party Date Relationship to Patient(s)