**Patient Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_

Primary Contact Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Contact Number: cell or work\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information**

ROY A. RAGGE, d.M.d. General & Cosmetic Dentistry

 Fellow Academy of General Dentistry

222 Jefferson Boulevard Telephone 401-736-5136

Warwick, RI 02888-3874 Fax: 401-736-0614

Welcome to our practice! We are pleased that you have chosen us for your dental care. Our practice realizes the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door!

At your first appointment, your provider will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, periodontal health evaluation, and examination of your teeth and soft tissues. Following this exam, your provider will discuss their findings with you, develop a treatment plan that you are comfortable with, and then you will be scheduled according to your needs.

 If you have dental insurance, be sure to provide all requested information to assist us in the benefit verification process. Also, read over our section on dental insurance for more information.  Payment is expected at the time of the first visit. If you are covered by insurance, we will expect payment of your portion at the time of service unless prior arrangements are made. As a courtesy, we will file claims on your behalf with your dental insurance company. If you would like to finance your dental expenses we work with CareCredit and will be glad to provide you with information about CareCredit and how to apply. If you have any questions about finances please feel free to ask us at any time.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of care and delays completion of your treatment. If you need to reschedule your appointment, please call us at least 24 hours prior to your visit.

We very much appreciate your confidence in us and look forward to meeting with you!

Sincerely,

Dr. Roy A. Ragge` & Staff

Are you under a physician’s care now? YES/NO ~ If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized or had any type of surgery YES/NO ~ If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a head or neck injury? YES/NO~ If yes, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken, or currently take Fosamax, Boniva, Atonel, or any other bisphosphonates? YES/NO

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on a special diet? YES/NO Do you use tobacco? YES/NO Do you use alcohol? YES/NO

Do you take controlled substances? YES/NO If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Woman Only**

Pregnant or trying? YES/NO Taking birth control? YES/NO Nursing? YES/NO

**Are You Allergic To Any Of The Following**

Aspirin\_\_\_ Penicillin\_\_\_ Codeine\_\_\_ Local Anesthesia\_\_\_ Acrylic\_\_\_

Metal\_\_\_ Latex\_\_\_ Sulfa drugs\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle any that apply**

AIDS/HIV positive Cortisone Medicine Hemophilia Radiation Treatment

Alzheimer’s Disease Diabetes Hepatitis A Recent Weight Loss

Anaphylaxis Drug Addiction Hepatitis B or C Renal Dialysis

Anemia Easily Winded Herpes Rheumatic Disease

Angina Emphysema High Blood Pressure Rheumatism

Artificial Heart Value Epilepsy/Seizures High Cholesterol Scarlet Fever

Arthritis/Gout Excessive Bleeding Hives/Rash Shingles

Artificial Joints Excessive Thirst Hypoglycemia Sickle Cell Disease

Asthma Fainting/Dizzy Spells Irregular Heartbeat Sinus Trouble

Blood Disease Frequent Cough Kidney Problems Spina Bifida

Blood Transfusion Frequent Diarrhea Leukemia Stomach Disease

Breathing Problems Frequent Headaches Liver Disease Stroke

Bruise Easily Genital Herpes Low Blood Pressure Swelling of limbs

Cancer Glaucoma Lung Disease Thyroid Disease

Chemotherapy Hay Fever Mitral Valve Prolapse Tonsillitis

Chest Pains Hear t Attack Osteoporosis Tuberculosis

Cold Sores Heart Murmur Pain in Jaw Joints Tumors/Growths

Congenital Heart Disorder Heart Pacemaker Parathyroid Disease Ulcers

Convulsions Heart Trouble/Disease Psychiatric Care Yellow Jaundice

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read the above. I acknowledge that I have answered all questions correctly and honestly. I will not hold my dentist or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 PLEASE TURN OVER, FOR ADDITIONAL INFORMATION AND SIGNATURES

**Copays & Payments**

Our staff makes every effort to avoid any misunderstandings regarding your dental insurance. Please be aware that the amount that you are quoted for copayment on any dental procedure is an **ESTIMATE ONLY,**  It is your responsibility to know and understand your own insurance copayments and limitations. Our staff will be happy to assist you in filing all claims and predeterminations. All quotes given are estimates pending your insurance approval and payment. It is your responsibility for any and all balances not paid by your insurance company. By signing below you are acknowledging that you have read and understand this portion of our office policy.

**No Show & Cancellation Policy**

If a scheduled appointment is not kept or cancelled without 24 hours notice, you will be required to pay a missed appointment fee of $50.00

This fee is not covered by any insurance company and will be considered an out of pocket expense.

Appointments are typically made months in advance, so we ask that you please mark your appointments on your calendar. Our office will provide a courtesy call to remind you of your appointment one business day before your scheduled time. We will make every effort to reach or leave a message for you. It is your responsibility to inform us to any address changes. By signing below, you acknowledging that you have read and understand this portion of our office policy.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, fully understand the contents of these office policies and agree to abide by them. I hereby authorize the office of Dr. Roy A. Ragge`, DMD to furnish information to my insurance company regarding my dependent or myself.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HIPPA & Notice of Privacy Practices**

Please read and review the attached Notice of Privacy Practices for our office. Please feel free to ask us any questions you may have regarding them.

Consent for appointment confirmation – I authorize the office of Dr. Roy A. Ragge`, DMD, to leave a message on my answering machine as needed, to confirm my appointments or to relay other information as needed to coordinate care.

**Dr. Roy A. Ragge`, DMD**

**ACKNOWLEDGEMENT OF RECIEPT**

**NOTICE OF PRIVACY PRACTICES**

“You may refuse to sign the acknowledgement”

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received or reviewed a copy

 Of Dr. Roy A. Ragge`s notice of privacy practices.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 09/2014