



Nicholas Ritzcovan, DDS

PATIENT INFORMATION

Date _____
Patient's last name _____ First name _____ Middle initial _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ I prefer to be called _____

Birth date _____ Social Security # _____
Marital Status Single Married Separated Divorced Widowed

Home address _____ City, State, Zip code _____
Home phone () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____
Email Address(es) _____
Occupation _____ Employer _____

PREFERRED METHOD OF CONTACT/PERMISSION TO CONTACT

May we contact you in the following ways? Please check all that apply.
 Text
 Call
 Email

By providing this information you agree to allow Home Town Dental to contact you in the method selected above and authorize us to leave messages regarding appointments or schedule changes. Please Initial: _____

How did you learn about our office? _____ Our website _____ Google _____ Ins. Provider Network _____ Friend/Family Referral Other _____

CLOSEST RELATIVE/ Emergency Contact

Spouse or closest relatives name(s) _____
Title Mr. Mrs. Ms. Miss. Dr. Other _____ Relationship to patient _____
Address (if different than patient address) _____
Home Phone (If different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

PRIOR DENTIST

Prior Dentist Name _____ Address, City, State _____
Last seen _____

Other dentists/dental specialists now being seen: Name _____ City, State _____
Reason _____

PHYSICIAN

Patient's Physician _____ City, State _____
Last seen _____ Reason _____ Next appointment Most recent physical exam _____

Other physicians/health care providers being seen now: Name _____ City, State _____
Reason _____
Name _____ City, State _____
Reason _____

GENERAL INFORMATION

What concerns you about your teeth? _____
Why did you select our office? _____
Have you had any previous orthodontic treatment? Please describe. _____
Have any other family members been treated in this office? Please name them. _____
Do you think that any of your work or leisure activities affect your teeth or jaws? Please explain. _____

CONSENT TO TREAT

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids she/he deems appropriate to make a thorough diagnosis of my dental needs.
I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated.
I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

Signature of Patient _____ Date _____ Relationship to patient _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different than page 1) _____ City, State, Zip _____
Home phone () _____ - _____ Cell phone () _____ - _____ Email address(es) _____
Social Security # _____ Employer _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ **Group#** _____ **ID#** _____

Secondary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group# _____ ID# _____

OFFICE DENTAL INSURANCE NOTICE

To avoid misunderstanding regarding your dental insurance, we want to let you know that all professional services rendered are charged directly to the patient and that all patients are personally responsible for payment of fees. We will prepare all necessary forms and/or reports to help you obtain your benefits from your insurance company as a courtesy.

We do not render our services on the basis that insurance companies will pay our fees, nor should you expect that they will.

We are required by law to collect all co-payments, deductibles and co-insurance payments and are not allowed to forgive costs not covered by the insurance company. To do so would constitute as fraud.

Once statements are sent the balance is expected within 30 days to avoid interest or late fees. **Please Initial:** _____

MISSED APPOINTMENT NOTICE

A fee of \$75.00 will be assessed to patients that do not give our office a minimum of 24 hours advanced notice of cancelation. We do acknowledge that emergencies and illnesses do happen and we will make exceptions accordingly. We are booked far in advance and frequently have waiting lists; those patients who would like to be seen are being denied the opportunity for a timely appointment. Without 24 hours' notice we are unable to offer your time to another.

I have read and understand this policy. **Please Initial:** _____

Name _____



HOMETOWN

FAMILY DENTISTRY

31 Bailey Avenue , Ridgefield, CT 06877 , 203-431-3901

Nritzcovan2@gmail.com

Request for Radiographs and Records

Dear Doctor _____

Patient's Name: _____ has a new Patient Appointment in our office.

Prior to taking films this patient requested we contact your office regarding x-rays and pertinent dental records you may have on file.

Would you kindly forward to our office the following:

X Bitewings taken less than 19 months ago

x Full Mouth Series/ Panelipse taken less than 5 years ago. If digital please email in Dexis.

x Date of last Prophy

Please include written records of history of care if you deem it necessary.

Please send in DEXIS if available, otherwise JPEG

Thank you in advance for your time and consideration.

Sincerely,

Nicholas Ritzcovan, DDS

I hereby authorize the release of dental records, including x-rays to Home Town Dental, PC

Patient Signature

Email x-rays to : nritzcovan2@gmail.com

Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:	Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>
Last First Middle _____	()	()
Address:	City:	State: Zip:
Mailing address		
Occupation:	Height:	Weight: Date of birth: Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship: Home Phone: Cell Phone:
		() () <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems:	(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Active Tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK				
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes	No	DK				Yes	No	DK
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.											
			Yes	No	DK				Yes	No	DK
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No	DK	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Name of physician or dentist making recommendation:						Phone:					
Do you have any disease, condition, or problem not listed above that you think I should know about?											
Please explain: _____											

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
 I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____



Acknowledgement of Receipt of Notice of Privacy Practices

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices. (Page 1 of 2)

Print Name: _____

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)

31 Bailey Ave Suite C
Ridgefield, CT. (203) 431-3901
HOMETOWN DENTAL



HIPAA Authorization Form for Family Members and Friends

I, _____, grant permission to Dr. Nicholas Ritzcovan to disclose and release my protected health information (PHI) to the following persons:

Name (s):

Relationship:

Health Information to be disclosed:

- My complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions dental and/or medical related)

OR My complete health record, as above, **with the exception** of the following information: (Check as appropriate):

- Mental health records
- Communicable diseases (including HIV and AIDS)
- All dental records
- Other (please specify):

 This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

This authorization shall be effective until (check one):

- All past, present, and future periods,
- OR** Until date or event: _____ unless I revoke it. (NOTE: You may revoke this authorization at any time by notifying us in writing.)

 Printed Name of the Person Giving this Authorization

 Signature of the Person Giving this Authorization

 Date