DR. RUIZ & ASSOCIATES

CONFIDENTIAL PATIENT INFORMATION

Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you. PLEASE PRINT OR WRITE LEGIBLY

Date: _____

PERSONAL INFORMATION

Name: _____ Preferred Name: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ S ☐ M ☐ D Spouse's Name: _____

Date of Birth: _____ S.S.#: _____

Driver's License #/ ID: _____ Expires: _____

Address: _____
STREET CITY STATE ZIP

Email Address: _____

Telephone: Home: _____ Cell: _____

Present Employer: _____ Business Phone: _____

Business Address: _____
STREET CITY STATE ZIP

Occupation: _____ Referred By: _____

PERSON RESPONSIBLE FOR DENTAL ACCOUNT

(Indicate if self)

Name: _____ Relationship: _____ S.S.#: _____

Telephone: Home: _____ Business: _____ DOB: _____

PERSON TO BE CONTACTED IN AN EMERGENCY - NOT LIVING WITH YOU

Name: _____ Relationship: _____ Phone: _____

DENTAL INSURANCE INFORMATION & AUTHORIZATION

Primary Insurance Co.: _____ Phone #: _____

Employer: _____ Group #: _____

Employee's Name: _____ Relationship: _____

S.S.# or Ins. ID: _____ DOB: _____

I authorize the insurance company indicated on this 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 services performed whether or not paid by an insurance company.

Signature: X Date:

HEALTH INFORMATION

	Yes	No
1. Have you been hospitalized within the past 2 Years? _____	☐	☐
2. Are you currently being treated by a physician?	☐	☐
If yes, for what? _____		
Your Physician's: Name: _____ Phone #: _____		
3. Are you, or could you, be pregnant?	☐	☐
4. Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	☐	☐
If yes, what? _____		
5. Are you allergic to any metals or jewelry?	☐	☐
If yes, what? _____		
6. Are you allergic to any drugs?	☐	☐
If yes, what? _____		
7. Do you bleed excessively upon injury?	☐	☐
If yes, please explain: _____		
8. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐
9. Have you ever received any counseling for excessive use of alcohol and/or prescription drugs?	☐	☐
If yes, please explain: _____		

MEDICAL CONDITIONS

	Yes	No
Abnormal Bleeding	☐	☐
AIDS or HIV Infection	☐	☐
Artificial Heart Valves or Joints	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer/Chemotherapy/Radiation Treatment _____	☐	☐
Cardiovascular Disease. If yes, specify below: _____	☐	☐
Diabetes. If yes, specify below: ___Type I (Insulin dependent) ___Type II	☐	☐
Epilepsy	☐	☐
Glaucoma	☐	☐
Hemophilia	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐
Kidney Problems		

	Yes	No
Paget's Disease / Osteoporosis	☐	☐
Medications Such As: Fosamax, Actonel, Boniva, Zometa, Aredia	☐	☐
High Blood Pressure	☐	☐
Mental Health Disorders. If yes, specify: _____	☐	☐
Respiratory Problems. If yes, specify: _____	☐	☐
Sexually Transmitted Diseases	☐	☐
Stroke	☐	☐
Tuberculosis	☐	☐
Thyroid Problems	☐	☐
Snoring or Stop Breathing at Night	☐	☐

Do you have any disease or condition not listed above that you think we should know about? Please explain:

_____

_____

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

Signature: X Date:

CELL PHONE AND ELECTRONIC COMMUNICATION AUTHORIZATION

I give consent to the dental practice to use my cell phone number to call or text regarding appointments and to call regarding treatment, insurance and my account.

I agree that the dental practice may communicate with me electronically at the email address and/or through texts at the cell phone number I provided. I am aware that there is some level of risk that third parties may be able to read unencrypted emails and/or texts. I am responsible for providing the dental practice any updates to my information. I can withdraw my consent to cell phone and/or electronic communications by calling: 818.558.4332.

Initials

Initials I consent to communication using my cell phone for ☐ calls and/or ☐ texts

Initials I consent to unencrypted email communication for non-sensitive matters

Initials I do not consent to communication via email or cell phone

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent.

I have had full opportunity to read and consider the contents of this Consent; and have received your Notice of Privacy Practices. I understand that, by signing, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

List any family members with whom we may disclose health information. **If not listed we are unable to disclose any information without additional written consent.**

_____ **Initials:** Initials

Signature: X Date:

Dental History Form

PATIENT NAME: (PREFERRED): DATE:

Please describe the primary reason for your visit (concerns):

1. _____

2. _____

3. _____

4. How long has this been going on and what would you like done?

_____

_____

5. If you could rate your smile from 1 - 10, what would it be? _____

6. Would you like to improve your smile? Y N How? _____

_____

Have you ever suffered from, or been told you may have any of the following?

7. Gum disease	Y	N	11. Sleep: Snoring/Stop Breathing	Y	N
8. Bruxism or Grinding	Y	N	12. Bad Breath	Y	N
9. Jaw pain or TMJ	Y	N	13. Headaches or Migraines	Y	N
10. Dental pain	Y	N	14. Tooth Sensitivity to Hot/Cold	Y	N

DOCTOR'S NOTES: _____

J LUIS RUIZ DDS, & ASSOCIATES INC., A PROFESSIONAL DENTAL CORPORATION

FINANCIAL POLICY

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The practice depends upon reimbursement from patients for the cost incurred in their care and financial responsibility on the part of the patient must be determined before treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

USUAL AND CUSTOMARY FEES
Our practice provides the very best treatment for our patients, using the best technology and materials and we charge a fair fee competitive with other offices in our area that provides similar quality of services. Please feel free to ask any questions you may have.

PAYMENT
Please be advised that in order to reserve your appointment, we require a 30% deposit.

INTEREST CHARGES
Our office does not provide a billing service and in an effort to avoid passing administrative charges on to our patients, our policy is for all accounts to remain current. Accounts that have not been paid will be subject to a finance charge at the rate of 1.5%, and may be subject to collection activity. Please note: there is a $45.00 charge for any returned checks.

INSURANCE ON ASSIGNMENT
We may accept assignment of insurance benefits, however all dental services furnished are charged directly to you the patient. Payment is your responsibility whether your insurance company pays or not, and regardless of any insurance company's arbitrary determination of usual and customary services.

Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services. As a service to you insurance claims are submitted promptly after treatment is rendered and we make every effort to receive payment on your behalf. However if your insurance company has not paid your account in full within 60 days, the balance of the account will be your responsibility. We will continue to assist you in any way that we can to receive payment and we are always available to answer your questions.

EMERGENCY SERVICES
All emergency dental services must be paid for in full, at the time services are performed. We will as a courtesy file any necessary insurance claims for you so you may obtain reimbursement directly.

MINOR PATIENTS
The adult accompanying a minor and/or the parents/guardians are responsible for full payment and accept financial responsibility for services rendered. For *unaccompanied* minors non-emergency treatment will be denied unless charges have been pre-paid prior to the treatment being performed.

MISSED APPOINTMENTS
Unless canceled at least 72 hours in advance, our policy is to charge for missed appointments at the rate of $250.00 for each hour reserved with the Doctor, and $100.00 for an appointment missed with the Hygienist. Please help us to serve you better by keeping scheduled appointments. **Every hygiene appointment will require a credit card on file, including patients with insurance.**

Thank you for understanding our financial policy. Please let us know if you have questions or concerns.

I have read, understand and agree to the provisions of this financial policy.

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY ***DATE***

PATIENT ACKNOWLEDGEMENT OF DENTAL MATERIALS FACT SHEET

I acknowledge that a copy of the Dental Materials Fact Sheet Dated October 2001 has been made available to me for review from J. Luis Ruiz DDS, & Associates Inc.

_____ _____

PATIENT SIGNATURE *DATE*