WELCOME

1 ABOUT YOU

Today's Date: ____/____/____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: _____ SS#: _____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone #: (_____) _____

Work Phone #: (_____) _____ Ext: _____

Cell Phone #: (_____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation: _____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: _____

Do you have children? ❑ Yes ❑ No How many? _____

2 INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

3 ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

_____
CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (_____) _____

Payment method: ❑ Cash ❑ Check

_____ ____/____

❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 EMERGENCY CONTACT

Whom should we contact? _____

Relation: _____

Home Phone #: (_____) _____

Work Phone #: (_____) _____

Cell Phone #: (_____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (_____) _____

CONTINUE ON BACK

5 DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation Are you in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw ❑ Lost/Broken Filling(s) ❑ Stained teeth ❑ Broken/Chipped tooth
❑ Blisters/Sores in or around the mouth ❑ Teeth grinding ❑ Locking Jaw ❑ Sensitive tooth, teeth or gums
❑ Red, swollen or bleeding gums ❑ Ringing in Ears ❑ Bad breath ❑ Active Decay/Cavity(ies)

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Have you ever been treated for Gum Disease? ❑ Y ❑ N

Previous Dentist: _____ (____) _____
Name Address Phone#

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___ Last Dental Cleaning: ___/___/___

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush?____ Times a week you floss?____ Type of tooth brush bristles? ❑ Soft ❑ Medium ❑ Hard

Rate your Smile from (EXCELLENT=10) 1-10: _____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile? _____

6 MEDICAL HISTORY & INFORMATION

What medications are you taking? ❑ Nerve pills ❑ Pain killers (including aspirin) ❑ Muscle relaxers ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Meds for Osteoporosis ❑ **Vitamins/Supplements** _____
❑ Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	Y N Heart Attack/Stroke	Y N Heart Surg./Pacemaker	Y N Heart Disease/Angina	Y N Shingles
Y N Lung Disease	Y N Thyroid Problems	Y N Congenital Heart Defect	Y N Cancer/Tumor(s)/Growth(s)	Y N Hepatitis
Y N Liver Problems	Y N Seizures/Epilepsy	Y N Artificial Heart Valves	Y N Chemotherapy/Radiation	Y N Glaucoma
Y N Blood Disease	Y N Venereal Disease	Y N Mitral Valve Prolapse	Y N X-ray or Cobalt Treatment	Y N Arthritis/Gout
Y N Kidney Problems	Y N Cosmetic Surgery	Y N G.I. Problems/Ulcers	Y N Frequent Thirst/Urination	Y N Leukemia
Y N Scarlet Fever	Y N Dizziness/Fainting	Y N Emphysema/Asthma	Y N Bleeding Problems/Anemia	Y N Chest Pains
Y N Tuberculosis TB	Y N Cold/Fever Blisters	Y N Diabetes/Hypoglycemia	Y N High/Low Blood Pressure	Y N Bruise Easily
Y N HIV+/AIDS/ARC	Y N Blood Transfusion	Y N Psychiatric Problems	Y N Artificial Bones/Joints/Implants	Y N Allergies
Y N Rheumatic Fever	Y N Alcohol/Drug Abuse	Y N Back/Neck Problems	Y N Severe/Frequent Headaches	Y N Nervousness
Y N Sinus Problems	Y N Eating Disorder	Y N Respiratory Problems	Y N Jaw Problems TMJ/TMD	Y N Sleep Apnea

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Codeine
❑ Dental Anesthetics ❑ Foods: _____ ❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No Are you taking hormonal replacement? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Y ❑ N How many children have you had? _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ Initials **I acknowledge that I have received a copy of the Summary of Privacy Notice.**

Signature _____ Date ___/___/___
❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

Initials ___/___/___ Date
Comments

East Brunswick Family & Implant Dentistry
Gabriel Ruiz, D.M.D. & Associates

To My Valued Patient,

The goal of our dental team is to obtain optimal dental health for you and your family. We feel a personal, professional and ethical responsibility to care for your oral health. With that said the scope of your oral health lies on your compliance with treatment, good quality home care and maintaining a proper oral health maintenance program with our office and/or recommended specialists. Missed appointments and failure to comply with our recommended treatment schedules and /or procedures prevent us from achieving our goal for your optimum dental health. If you cannot keep your appointments and do not adhere to our treatment recommendations, we will not be able to continue treating you in good conscience. Therefore the following must be agreed upon:

- **Broken appointments.** Our office is committed to accommodating your scheduling needs. In return, we expect 24 hours notice prior to rescheduling or canceling an appointment. This will allow us the opportunity to offer that appointment to another patient and we can reschedule your appointment. There is a $50 fee for all broken appointments and this fee is not covered by insurance.

- **Timeliness is required**. We will do our best to see you on time and get you out on time unless there is an emergency. We request that you be on time for your visits.

- **Cleanliness and infection control are of the utmost importance**. We have the latest sterilization technology and disinfect each treatment room after each patient. We request that you brush your teeth prior to your given appointment.

- **If you miss an appointment you must make it up.** It is critical to your health to do so to avoid setbacks in the care and maintenance of your teeth and gums.

- **Insurance:** Treatment recommendations are based on your health not on your insurance or lack thereof. You agree to be financially responsible for either the full amount of treatment, or the balance after payment by your dental insurance company should the claim be denied or be processed at a lesser benefit level. Your benefits are a contract between you and your insurance company.

- **We run a Zero Balance office.** We expect your deductible and/or co-payment to be paid in full at the time treatment is provided. We have several financial options available for all of our patients. Please speak to our front office team if you have any questions.

- **Our policy is to make your experience in our office an exceptional one.** When we succeed, we would appreciate you telling your family and friends about our office.

- **Concerns.** It is our policy to ensure the complete satisfaction of all of our patients with the service and care they receive at our office. If there is a misunderstanding or miscommunication between you and our office, we will do everything in our power to make things right. This matter should be brought to our attention in an appropriate cordial manner at a time that we can give it the proper attention it deserves for an effective resolution. You can expect that my team will treat you with the same professional demeanor and efficiency as you would expect from them. We will act immediately to resolve any upset that you may have with our office or one of our team members.

- **Emergencies.** It is our goal to eliminate all of the potential dental emergencies you may have by providing care for you before it becomes a problem. In the rare instance that you do have an emergency, we want you to be assured that we will take care of you. In order to do this we would like to define what a true emergency is. Swelling, bleeding, severe pain that has kept you up at night or require medication, or a restoration in a visible area that falls out are all considered emergencies. If you have any of these symptoms, we ask that you call us right away. We will provide you with the next available emergency appointment. We do set aside time each day for emergencies.

We greatly appreciate your cooperation.

Yours in Health,

Gabriel Ruiz, D.M.D.

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Patient Signature	Date	Office

561 CRANBURY RD., SUITE K, EAST BRUNSWICK, NJ 08816· (732) 238-6660· Fax (732) 651-0133