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)

____ Initials 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).

4 IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

5 DENTAL INFO

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
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: _____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

6 MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **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 Attack / Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surg./Pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Arthritis/ Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach Problems/Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric Problems	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Frequent Headaches	Y N High/Low Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

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

❑ 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 How many children have you had? _____

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- 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.

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

Initials _____

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

UPDATE
(OFFICE USE)

Initials ____ Date ____ / ____ / ____
Comments

Initials ____ Date ____ / ____ / ____
Comments

Initials ____ Date ____ / ____ / ____
Comments

Drum Point Family & Implant Dentistry PC
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.

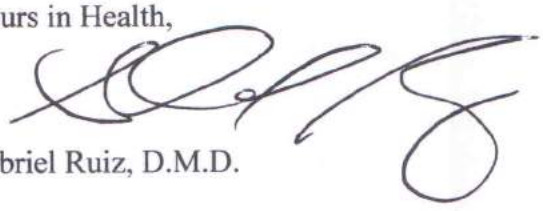
- **Our policy is to make your experience in our office an exceptional one.** When we succeed, we would appreciate you telling your family and friends about our office.

- **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.

----------	----------	----------
Patient Signature	Date	Office

131 Drum Point Rd., Brick, NJ 08723 Telephone 732.451.0400 Fax 732.451.0500

Drum Point Family and Implant Dentistry

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Insurance Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Drum Point Family and Implant Dentistry
131 Drum Point Rd
Brick, NJ 08723

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You May Refuse to Sign This Acknowledgement*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Please Print Name **Date**

_____
Signature

Other family members, or significant others that we can release information to.

_____

_____

Office Use

_____

The Patient refused to sign our Notice of Privacy Practices Because:

_____

_____