# RUBY DENTAL

## PATIENT INFORMATION FORM

Today Date:_____

Patient Name: First_____Last_____

Address Street_____City_____St_____Zip_____

Phone: Home_____Work_____Mobile_____

Email address:_____

SSN:_____ DOB:_____

Drivers License#:_____State:_____

Employer:_____Phone:_____

Sex: Male___Female___ Marital Status: Married_____Single____

In Case of emergency: First name_____Last Name_____

phone_____Relationship to patient_____

Is patient a minor? yes___No___

Name of Responsible party: First_____Last_____

DOB:_____ Relationship to patient:_____

## DENTAL BENEFIT PLAN INFORMATION

Primary Dental Plan Name_____Phone_____

Address: Street_____City_____ST_____Zip_____

Name of Insured_____DOB_____ID #_____

Patient Relationship to Insured:_____

Secondary Dental Plan Name_____Phone_____

Address: Street_____City_____ST_____Zip_____

Name of Insured_____DOB_____ID #_____

Patient Relationship to Insured:_____

## MEDICAL AND DENTAL HISTORY

Reason For Visit:_____

Were You Referred/By Who?_____

Any Discomfort? If Yes Where and When?_____

Last Dental Visit?_____

Current Medical Doctor Name:_____

Address:_____

Phone:_____Fax:_____

# RUBY DENTAL

## MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive ◯ Yes ◯ No | Cortisone Medicine ◯ Yes ◯ No | Hemophilia ◯ Yes ◯ No | Radiation Treatments ◯ Yes ◯ No |
| Alzheimer's Disease ◯ Yes ◯ No | Diabetes ◯ Yes ◯ No | Hepatitis A ◯ Yes ◯ No | Recent Weight Loss ◯ Yes ◯ No |
| Anaphylaxis ◯ Yes ◯ No | Drug Addiction ◯ Yes ◯ No | Hepatitis B or C ◯ Yes ◯ No | Renal Dialysis ◯ Yes ◯ No |
| Anemia ◯ Yes ◯ No | Easily Winded ◯ Yes ◯ No | Herpes ◯ Yes ◯ No | Rheumatic Fever ◯ Yes ◯ No |
| Angina ◯ Yes ◯ No | Emphysema ◯ Yes ◯ No | High Blood Pressure ◯ Yes ◯ No | Rheumatism ◯ Yes ◯ No |
| Arthritis/Gout ◯ Yes ◯ No | Epilepsy or Seizures ◯ Yes ◯ No | High Cholesterol ◯ Yes ◯ No | Scarlet Fever ◯ Yes ◯ No |
| Artificial Heart Valve ◯ Yes ◯ No | Excessive Bleeding ◯ Yes ◯ No | Hives or Rash ◯ Yes ◯ No | Shingles ◯ Yes ◯ No |
| Artificial Joint ◯ Yes ◯ No | Excessive Thirst ◯ Yes ◯ No | Hypoglycemia ◯ Yes ◯ No | Sickle Cell Disease ◯ Yes ◯ No |
| Asthma ◯ Yes ◯ No | Fainting Spells/Dizziness ◯ Yes ◯ No | Irregular Heartbeat ◯ Yes ◯ No | Sinus Trouble ◯ Yes ◯ No |
| Blood Disease ◯ Yes ◯ No | Frequent Cough ◯ Yes ◯ No | Kidney Problems ◯ Yes ◯ No | Spina Bifida ◯ Yes ◯ No |
| Blood Transfusion ◯ Yes ◯ No | Frequent Diarrhea ◯ Yes ◯ No | Leukemia ◯ Yes ◯ No | Stomach/Intestinal Disease ◯ Yes ◯ No |
| Breathing Problem ◯ Yes ◯ No | Frequent Headaches ◯ Yes ◯ No | Liver Disease ◯ Yes ◯ No | Stroke ◯ Yes ◯ No |
| Bruise Easily ◯ Yes ◯ No | Genital Herpes ◯ Yes ◯ No | Low Blood Pressure ◯ Yes ◯ No | Swelling of Limbs ◯ Yes ◯ No |
| Cancer ◯ Yes ◯ No | Glaucoma ◯ Yes ◯ No | Lung Disease ◯ Yes ◯ No | Thyroid Disease ◯ Yes ◯ No |
| Chemotherapy ◯ Yes ◯ No | Hay Fever ◯ Yes ◯ No | Mitral Valve Prolapse ◯ Yes ◯ No | Tonsillitis ◯ Yes ◯ No |
| Chest Pains ◯ Yes ◯ No | Heart Attack/Failure ◯ Yes ◯ No | Osteoporosis ◯ Yes ◯ No | Tuberculosis ◯ Yes ◯ No |
| Cold Sores/Fever Blisters ◯ Yes ◯ No | Heart Murmur ◯ Yes ◯ No | Pain in Jaw Joints ◯ Yes ◯ No | Tumors or Growths ◯ Yes ◯ No |
| Congenital Heart Disorder ◯ Yes ◯ No | Heart Pacemaker ◯ Yes ◯ No | Parathyroid Disease ◯ Yes ◯ No | Ulcers ◯ Yes ◯ No |
| Convulsions ◯ Yes ◯ No | Heart Trouble/Disease ◯ Yes ◯ No | Psychiatric Care ◯ Yes ◯ No | Venereal Disease ◯ Yes ◯ No |
| | | | Yellow Jaundice ◯ Yes ◯ No |

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

# RUBY DENTAL
# FINANCIAL AGREEMENT

## FINANCIAL AGREEMENT

Payment in full for all charges is required at time of visit, unless prior arrangements have been made.

## INSURANCE FILING

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our Patients. It is the patient responsibility to inform us if they have a secondary insurance (ex. Medicaid, CHIPS, 2nd PPO Plan). We can give estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event you'r insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient or the patient/guardian.

## ASSINGMENT OF INSURANCE BENEFITS

I/We hereby assign directly to Ruby Dental, Dental insurance benefits otherwise payable to me/us. I/we hereby authorize the release of any information relating to any claims. I/we understand I/we are financially responsible for charges not paid by this assignment.

In the event that the Insurance Company should mistakenly send payment to me for services rendered by Ruby Dental I will remit payment to you my Dental provider "Ruby Dental".

## DELINQUENT ACCOUNTS

All delinquent accounts (30 days or older) are subject to a billing service charge and/or legal interest rates.

## COLLETION PROCEDDINGS

In the event your account is turned over to a collection agency for non-payment or other delinquency, you will be responsible for payment of any collection costs (30%) and/or attorney fee, you will be responsible for payment of any collection agency forfeits any past special fees and/or discounts. Such special fees and /or discounts will be reversed and you will be responsible for payment of regular fee procedures at the time of service.

# NOTICE OF PRIVACY POLICIES

**I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right ot revoke permission.**

**PRINTED PATIENTS NAME:**_____

**DOB:**_____

**RESPONSIBLE PARTY SIGNATURE:**_____

**WITNESS/TITLE:**_____ **TODAY'S DATE:**_____

# RUBY DENTAL

**GENERAL DENTISTRY INFORMED CONSENT**

1. **WORK TO BE DONE**

   I understand that I am having the following work done: Fillings ____, Bridges ____, Crowns ____, Extractions ____, Root Canal ___, Exams & X-Ray ___, Other _____.

2. **DRUG, MEDICATIONS AND SEDATION**

   I understand that antibiotics, analgescs and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching and/or anaphylatic shock (severe allergic reaction) and they can cause pain thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections, injury to and stiffening of neck and facial muscles. They may cause drowsiness and lack of awareness and coordination which can be increased by use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effect of the anesthetic, medication and drugs that may be given to me in the office for my care. I understand that failure to take medication prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. On occasion, you may experience prolonged numbness (parathesia) of lower lip, skin and tongue after the injection of a local anesthetic. This should be temporary and normal sensation should come back. I understand that antibiotics can reduce the effectiveness of oral contraceptives.

3. **CHANGE IN TREATMENT PLAN**

   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination- the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any or all changes and additions as necessary.

4. **FILLINGS**

   I understand that care must be exercised in chewing on filling during the first 24 hours to avoid breakage. Tooth sensitivity is common after-effect of a newly placed filling.

5. **CROWNS, BRIDGES, VENEERS AND BONDING**

   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temproary crowns, which may come off easily and that I must be careful to ensure bridge or cap (including shape, fit, size, placement and color) will be done before cementation. I understand that in very few cases, cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures.

6. **ENDODONTIC TREATMENT**

   I realize there is no guarantee that root canal treatment will save a tooth and complications can occur from the treatment and that occasionally metal objects are cemented in the tooth, or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy)

7. **PERIODONTAL TREATMENT**

   I understand that serious periodontal conditions causing gum inflammation and/or bone loss can lead to the loss of my teeth. I understand that treatment plans (non-surgical cleaning, gum surgery and/or extractions) may vary depending on the severity of my periodontal conditions. I understand the success of a treatment depends in part on my efforts to brush and floss daily, receiving regular cleaning as directed, following a healthy diet, avoid tabocco products and follow other recommendations.

8. **REMOVAL OF TEETH (EXTRACTION)**

   I understand that if a tooth is not savable by e.g. root canal therapy, crowns, periodontal surgery, etc., it may be recommended that the tooth be extracted. I understand removing teeth does not always remove all infection if present and it may be necessary to have further treatment.i understand that the following are some risks involved in having teeth removed: pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (parathesia) that can last for an indefinite period of time or fractured jaw. I unerstand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

9. **DENTURES- COMPLETE OR PARTIAL**

   I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement and color) will be "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure in not included in the initial denture fees.

10. **TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)**

    I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. However, symptoms of TMJ associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise, then I will be transferred to a specialist for treatment, and the cost of which is my responsibility.

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist other than the treating dentist is responsible for my dental treatment.

Print : _____

Signature : _____ Date: _____

Doctor: _____ Date: _____