Albert Ruiz D.D.S.

FAMILY & COSMETIC DENTISTRY

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1 About You

Today's Date:_____ **Name:** _____

I prefer to be called: _____ ☐ Male ☐ Female Birthdate: ___/___/___ Age _____

Home Address: _____ **City** _____ **State** _____ **Zip** _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Phone# _____ **Cell/Other #:** _____ **Wk #:** _____ **Ext** _____

Email: _____ Employer: _____ Occupation: _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Last Visit Date: _____ I am a ☐ Full time resident ☐ Winter resident

Special Interests, Sports or Hobbies? _____

2 Parent/Guardian Info and Financial Options

Parent/Guardian Name: _____ Employer: _____

Wk#: _____ Ext _____ Cell: _____

Payment is expected at the time of service, listed are your available payment options.

Financial Options: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX ☐ Cash ☐ Personal Check

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

Patient's Social Security #: _____

Insured's Name: _____ Relation: _____

Insured's Birthday: __/__/__ Insured's SS#: _____

Insured's Employer or Retired From: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthday: __/__/__ Insured's SS#: _____

Insured's Employer or Retired From: _____

We accept a select group of dental insurances, most plans include coinsurance, a deductible and other expenses which must be paid by the patient at the time of service.

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes Physician's Name: _____ Phone#: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes Please explain _____

Are you taking any blood thinners? ☐ No ☐ Yes _____

Do you smoke or use tobacco in any form? ☐ No ☐ Yes _____

Are you taking any prescription / over-the-counter drugs? ☐ No ☐ Yes

Please list each one _____

FOR WOMEN: Are you taking birth control pills? ☐ **No** ☐ **Yes**

Are you pregnant? ☐ **No** ☐ **Yes** **Week#**_____ **Are you nursing?** ☐ **No** ☐ **Yes**

OVER →

5 DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? ☐ No ☐ Yes

Have you ever had a serious/difficult problem associated with any dental treatment or procedure? ☐ No ☐ Yes

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ☐ No ☐ Yes

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Would you like a whiter smile? ☐ No ☐ Yes Do your gums ever bleed? ☐ No ☐ Yes

How many times a week do you floss? _____ How many times a day do you brush? _____

Do you use ☐ Manual Toothbrush ☐ Battery Powered Toothbrush

Are your teeth sensitive to heat, cold, or anthing else? ☐ No ☐ Yes _____

Do you require antibiotics before dental treatment? ☐ No ☐ Yes

Do you have any history of periodontal disease or gum surgery? ☐ No ☐ Yes Date: _____

Do you grind your teeth? ☐ No ☐ Yes

Do you wear removable dental appliances? ☐ No ☐ Yes

Have you ever had orthodontic (braces) treatment? ☐ No ☐ Yes

Have you ever had any of the following diseases or medical problems?

Y	N	Anemia/Radiation Treatment	Y	N	Epilepsy/Seizures/Fainting Spells	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints	Y	N	Fever Blisters	Y	N	Mitral Valve Prolapse
Y	N	Artificial Valves	Y	N	Heart Attack/Stroke	Y	N	Osteoporosis
Y	N	Asthma/Arthritis	Y	N	Heart Murmur	Y	N	Psychiatric Problems
Y	N	Blood Transfusion	Y	N	Heart Surgery/Pacemaker	Y	N	Rheumatic Fever
Y	N	Cancer/Chemotherapy	Y	N	Hemophilia/Abnormal Bleeding	Y	N	Severe/Frequent Headaches
Y	N	Congenital Heart Defect	Y	N	Hepatitis	Y	N	Shingles
Y	N	Diabetes/Tuberculosis (TB)	Y	N	High/Low Blood Pressure	Y	N	Sinus Problems
Y	N	Difficulty Breathing	Y	N	HIV+/Aids	Y	N	Venereal Disease
Y	N	Drug/Alcohol Abuse	Y	N	Hospitalized for Any Reason	Y	N	Ulcers/Colitis
Y	N	Emphysema/Glaucoma	Please list _____					

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs that you are allergic to:

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ **Relation:** _____

Wk#: _____ **Hm#:** _____

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

Signature _____ Date _____

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials _____ Date _____