J. LUIS RUIZ, DDS & ASSOCIATES, INC.

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
Osteoporosis/Medicated	☐	☐
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:

Updated Medical History

Has there been any change in your medical history or new medications from above? _____

_____

_____

_____

Signature: X Date:

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:** ☐

Signature: X Date: