WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? X _____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

X _____ and assign directly to
Name of Insurance Company(ies)

Dr. Norma A Ramirez 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 or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

X _____
Signature of Patient, Parent, Guardian or Personal Representative

X _____
Please print name of Patient, Parent, Guardian or Personal Representative

X _____ X _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Chew on one side of mouth	☐ Yes	☐ No	Mouth pain, brushing	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
			Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
			Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
			Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
			Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
			Foreign objects	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
			Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
			Gums swollen or tender	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No
			Jaw pain or tiredness	☐ Yes	☐ No	How often do you floss? _____		
			Lip or cheek biting	☐ Yes	☐ No			
			Loose teeth or broken fillings	☐ Yes	☐ No	How often do you brush? _____		

HEALTH HISTORY

Physician's Name _____ Date of last visit_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
		High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Cortisone Treatments	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due date_____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin

☐ Barbiturates (Sleeping pills)

☐ Codeine

☐ Iodine

☐ Latex

☐ Local Anesthetic

☐ Penicillin

☐ Sulfa

☐ Other _____

_____

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications?_____ If so, what? _____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Our Guidelines and Financial Policy

We are pleased to inform you as to our dental care guidelines and financial policy along with general information about our practice. If you carry dental Insurance and desire our office to process your dental claims, we are happy to assist with this process. As you may be aware, dental insurance does not always cover full cost of treatment and/or deny payment completely. In those instances, patients are responsible for any amount via the insurance company does not pay for any reason. We thank you for allowing us to serve you with your health care needs.

1. **DENTAL SERVICES:** Full payment or co-payment is due at the time of each visit. As a form of payment, we accept cash, checks, Master Card and Visa. We have a returned check policy of $20.00 if this should occur for processing bank fees. If you desire to pre-pay for service, we will honor a savings up to 5% for Visa or Master Card payments or savings up to 10% for Cash, Check, or Money Order payments.

2. **INSURANCE BILLING:** Patients who wish for our office to bill their insurance company, we require you to provide us with the necessary information in order to bill your insurance correctly. You are responsible for full balances your dental insurance does not pay within 45 days from service visit. Your dental insurance is a contract between you, your employer and/or your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be a non-covered service under you dental plan. Co-pays collected are estimates only. Our practice is committed to the best treatment for our patients and our fees are based on usual and customary for our area. You are responsible for any payment regardless of arbitrary determination of usual and customary rates by insurance companies.

3. **LATE AND MISSED APPOINTMENTS:** Patients arriving 15 minutes late into their scheduled appointments, it may be necessary to reschedule, in order to meet the needs of those patients who are on time for their pre-reserved visit. If we do not receive a 24-hour prior notice of the change in appointment, we charge one hundred dollars ($100.00) per hour for a missed appointment with the doctor and fifty dollars ($50.00) with our hygienist.

4. **FINANCIAL ARRANGEMENTS:** If your account is turned over to our bookkeeper for collections and then placed in the hands of an attorney, there will be additional fees incurred for this service. We desire to work with you and will do so if informed of such.

5. **DENTAL SERVICES FINANCING:** We work with various financing companies to provide affordable dentistry. Upon approval we will be able to proceed forward with services within your budget and time commitment

6. **VIP QUICK PAY:** For balances due, we have designed a program by which we simply maintain your VISA, MC, AMEX, DISC on file to capture any co-payments and balances after your dental insurance has paid its portion. This balance may include deductibles and denial as well as non-covered services. We offer this as a service to all our patients. If interested, please fill out our Easy Pay Consent below.

Credit Card # _____ Exp: _____ Patient Signature_____ Date_____

By Singing below, you agree to our Guidelines and Financial Policy. Thank you for understanding.

Patient Signature X_____ Date X_____