# Ruiz Family Dental

1600 Coulter, Bldg. G, Suite 500/ Amarillo, Texas 79106
(806) 351-2762/ 1-866-803-GUMS

## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Any Time ☐M ☐T ☐W ☐T ☐F

Address: _____
Street Apartment # E-mail Address

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Pharmacy Used: _____ Phone # _____

**Have you ever had any of the following? Please check those that apply:**

☐ AIDS/ HIV +
☐ Allergies _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma (Inhaler?)
☐ Birth Control Pills
☐ Blood Disease
☐ Cancer (Chemotherapy/ Radiation Treatment)
☐ Colon Problems (Colitis)
☐ Diabetes
☐ Dizziness
☐ Endocarditis
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Attack
☐ Heart Disease (Angina/ Stents/ Valves)
☐ Heart Murmur
☐ Hepatitis or Jaundice
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy** Due date:_____
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Scarlet Fever
☐ Sexually Transmitted Disease
☐ Sinus Problems
☐ Steroids (past 2 years)
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease (Hyper or Hypo)
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Codeine Allergy
☐ Penicillin Allergy

OTHER:
☐ Medications:
Allergic to:
_____
_____
_____

Presently taking:
_____
_____
_____

☐Do You Smoke?
How Much? _____
☐Do You Dip?
How Much? _____
☐Do You Drink Alcohol?
How Often? _____

_____
Doctor's Signature

Have you ever taken any of these Medications now or in the past? (Circle any taken)

Fosomax Actonel Evista Boniva Forteo Zometa Requip Didronel Menostar

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

## Person Responsible for Paym t

☐ self ☐ spouse ☐ parent or guardian

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Address: _____
Street Apartment # E-mail Address

_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Social Security #: _____ Birth Date: _____

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Authorization for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient,
parent or guardian / responsible party

## Acknowledgment of Privacy Practice

I have read and understand the Notice of Privacy Practices given to me by Dr. Michelle Ruiz and Dr. Danny Black with Ruiz Family Dental. I have been offered a copy of the Notice of Privacy Practice to keep for my records.

_____ _____

Signature of Patient, Parent or Guardian Date

# FEE PAYMENT INFORMATION

## Fee Payment Information

In an effort to inform you and to avoid misunderstandings, we feel that it is appropriate to outline our office policy on payment for professional services. Each patient is responsible for his/her account and payment is expected in full when services are rendered. For your convenience, we accept cash, checks, and credit cards (VISA and MasterCard). We also offer a payment plan option through the "**Care Credit**" program. There are some no interest payment plan options available (some restrictions apply). Patients who are interested in using this program must fill out an application and be approved in order to use it. You may request an application and more information from the office manager prior to treatment.

## DENTAL INSURANCE

If you have dental insurance, we will gladly submit any treatments performed on the day of service with your designated carrier. You will be required to pay your copay and any deductible at the time of the visit. If your insurance company HAS NOT paid on your claim within 45 days, then you will be immediately responsible for the remaining balance. Once your insurance company has reimbursed us, any money paid over your balance will be credited to your account for future treatments. If your insurance is one we are not in network with and they pay less than stated,you will be sent a statement for any remaining unpaid balance. Please remember that your insurance policy is a contract between You and Your Insurance carrier, NOT the dentist and the insurance carrier! Disputes regarding payment amounts, coverage, deductibles, and/or eligibility are between you and the insurance carrier. Our fees are NOT determined in cooperation with insurance companies and therefore some reimbursements may not cover the amount stated in your insurance policy.

If you have any questions regarding fees, filing of insurance or payment options, please seek assistance from our office manager prior to treatment.

In order for us to process your paperwork as quickly and efficiently as possible, we ask that you check the method of payment which you plan on using:

_____Cash/Personal Check

_____Credit Card (VISA or MasterCard)

_____Payment Plan* (Care Credit)
*must be pre-qualified

I have read all the information above and agree to abide by its content.

Signed: _____Date:_____