

PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Date of Birth: ____/____/____ SSN: _____ - _____ - _____ DL#: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Email address _____

Cell Phone: (_____) _____ Sex: Male Marital Status: Single Married Divorced

Work Number: (_____) _____ Female Separated Widowed

ACCOUNT INFORMATION

Who is responsible for paying this account? _____

Relationship to patient: Self Spouse Parent Other: _____

Responsible party's Full Name _____ DOB: ____/____/____

SSN: _____ DL#: _____

Address: _____ City _____ State _____ Zip Code: _____

Employer: _____ Employer's Phone: _____

Is the patient is a minor or dependent? If so, please provide the following:

Father's Name: _____ Mother's Name: _____

Phone(s): _____ Phone(s): _____

SSN: _____ SSN: _____

DOB: ____/____/____ DL#: _____ DOB: ____/____/____ DL#: _____

Employer Name/Phone #: _____ / _____ Employer Name/Phone #: _____ / _____

DENTAL INFORMATION

Please indicate if you have a preference for the following dentists: No Preference Dr. Pat Dr. Jan Dr. Nate

Previous Dentist: _____ Date of last dental exam: _____

How do you feel about your smile? _____

What, if anything, would you change about your smile? _____

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do your gums bleed when you brush? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had your teeth straightened? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been diagnosed as having periodontal (gum) disease? | <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of grinding or clenching your teeth? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever experienced a problem with local anesthesia? | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had TMJ treatment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get frequent blisters on your lips or in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> | Do you have removable appliance (denture/partial)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of any oral habits such as thumb sucking, nail biting, mouth breathing? (circle one) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are your teeth sensitive to heat, cold, sweets, or pressure? (circle one) | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any discomfort in your mouth presently? Specify _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have pain or clicking when opening or closing your jaw? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you aware of any swelling or lump in your mouth? Specify _____ | | | |

REFERRAL INFORMATION:

Whom may we thank for referring you to our office? Website Phonebook Insurance Other: _____

MEDICAL INFORMATION

Yes No

- Have you ever had your wisdom teeth extracted? If yes, when? _____
- Have you ever experienced a problem with local anesthesia?
- Have you ever had a serious head or neck injury?
- Have you ever been hospitalized or had a major operation?
- Are you taking any medications, pills, or drugs? If so, please explain: _____
- Are you on a special diet?
- Do you use tobacco?
- Do you take, or have you taken Phen-Fen or Redux?
- Do you use controlled substances?
- Do you take bisphosphonates (Fosamax, Boniva, etc.)?

Are you currently under the care of a physician? Yes No Physician Name/Phone #: _____/_____

If yes, what is/are the condition(s) being treated? _____

Women, Are you pregnant/trying to get pregnant? nursing? taking oral contraceptives?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex

Local Anesthetics Other – Please specify: _____

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

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joint, if so when _____ | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Persistent Cough that produces blood or persistent cough lasting longer than 3 weeks | | |

CONSENT:

The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient’s dental needs. I also authorize Doctor to perform any and all forms of treatment, medications, and therapy that may be in connection with (Patient’s Name) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made prior to the time of service. I further understand that a \$10.00 rebilling fee will be added to any balance over 90 days. In the event of default (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature _____ Date _____

Parent Signature (for minors/dependents) _____ Date _____

Relationship to Patient _____

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RUOPP & RUOPP D.D.S., P.C.
**CONSENT FOR USE AND DISCLOSURE OF HEALTH
INFORMATION**

NAME: _____

ADDRESS: _____

TELEPHONE: _____ **CELL PHONE:** _____

WORK NUMBER: _____ **E-MAIL:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER:** ____ - ____ - ____

INSURANCE COMPANY: _____

SUBSCRIBER NAME (POLICY HOLDER): _____

SUBSCRIBER NUMBER OR SSN: _____ **POLICY NUMBER:** _____

SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER PLACE OF EMPLOYMENT: _____

SUBSCRIBER ADDRESS (if different than patient address): _____

RELATIONSHIP TO SUBSCRIBER (please circle):

SELF SPOUSE CHILD OTHER

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

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 protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions or our Notices, at any time by contacting our office.

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you in you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Representative Name: _____ Relationship to Patient: _____

My protected personal health information may be disclosed to the following person(s) until such time as I choose to revoke it in writing:

Please indicate relationship to the patient for each person listed above.