

PATIENT INFORMATION

Date _____ Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Social Security # _____

E-Mail Address _____

Sex _____ Marital Status _____ Whom May We Thank For Referring You _____

Employer _____ Employer Address _____

Guarantor Information

Person Financially Responsible For This Bill _____ Relationship to Patient _____

Address If Different Then Above _____

Home Phone # _____ Work Phone # _____ Social Security # _____ DOB _____

Employer _____ Employer Address _____

Dental Plan Information

Name of Dental Plan _____ Subscriber's Name _____

Subscriber's Social Security _____ Date Of Birth _____ Sex _____

Address of Dental Plan _____

Group Number _____ Membership Identification Number _____

Emergency Information*

Person To Contact In Case Of Emergency _____

Address _____

Home Phone # _____ Work Phone # _____ Relationship _____

I Acknowledge I have received a copy of "Notice of Privacy Practices" and "Disclosure of Health Information"

Patient Signature (parent or guardian if minor) _____

RUBIN FAMILY DENTAL ASSOCIATES

DENTAL HISTORY

So that we may provide you with the best possible care, please complete this form as completely as possible.

Patient Name: _____ Medical Alert: _____

What is the reason for today's visit? _____

Date of last dental visit _____ Reason: _____

Date of last cleaning _____ Date of last x-rays _____

Previous dentist's name _____

Address _____

City/State/Zip _____ Phone _____

How often do you have dental check-ups? _____

How often do you brush? _____ Floss? _____

What dental aids do you use? _____

What dental problems do you have now? _____

(Please circle)

Are any of your teeth sensitive to:

hot or cold? Yes No

sweets? Yes No

biting or chewing? Yes No

Do you get cold sores or other oral lesions? Yes No

Have you ever been concerned about your breath? Yes No

Do you ever get a bad taste in your mouth? Yes No

Are you interested in preventing bad breath? Yes No

Are you currently using anything for breath control? Yes No

Do your gums bleed or hurt? Yes No

Do you notice any loose teeth or change in your bite? Yes No

Does food tend to get caught in your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Do you experience dry mouth? Yes No

Do you clench or grind teeth while awake? asleep? Yes No

Do you mouth breath while awake or asleep? Yes No

Have you noticed clicking or popping of the jaw? Yes No

Do you have difficulty opening or closing your mouth? Yes No

Do you have pain or difficulty chewing? Yes No

Do you have tired jaws, especially in the morning? Yes No

Would you like to keep all your teeth for life? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Rate your smile (on a scale of one to ten) _____

Are you interested in whitening your smile? Yes No

(Please circle)

Have you ever had:

Orthodontic Treatment? Yes No

Oral Surgery? Yes No

Periodontal Treatment? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

Your teeth ground or bite adjusted? Yes No

Pain in jaw, joint, ear or side of face? Yes No

Do you feel nervous about today's treatment? _____

What is your biggest concern? _____

What did you like best at your last dental office? _____

What did you like least? _____

Have you ever had an upsetting dental experience? Yes No

If yes, what was it? _____

Is there anything else we should know? Yes No

Please rank the following in the order in which they

would **KEEP YOU** from having treatment:

Fear of pain _____

Lack of concern _____

Cost of Treatment _____

Missing time from work _____

Embarrassed by current condition _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No

3. Are you taking any medication, drugs or pills now? (including over-the-counter or aspirin) Yes No

If yes, please list name and dosage _____

4. Are you aware of having an allergic (or adverse reaction) to any medication? Yes No

Do you have any allergic or adverse reactions to any substances? (including latex) Yes No

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Sore/Enlarged Lymph Nodes	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Hepatitis A - B - C	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	Venereal Disease	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	A.I.D.S.	Yes	No
Anemia	Yes	No	Contact Lens	Yes	No	H.I.V. Positive	Yes	No
Low Blood Pressure	Yes	No	Emphysema	Yes	No	Cold Sores/Fever Blisters	Yes	No
High Blood Pressure	Yes	No	Chronic Cough	Yes	No	Slow Healing Mouth Sores	Yes	No
Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Asthma	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Hay Fever	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Latex Sensitivity	Yes	No	Liver Disease	Yes	No
Arthritis/Rheumatism	Yes	No	Allergies or Hives	Yes	No	Yellow Jaundice	Yes	No
Cortisone Medicine	Yes	No	Sinus Trouble	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Bruise Easily	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Other Infections	Yes	No	Fainting or Dizzy Spells	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Nervous/Anxious	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Psychiatric/Psychological Care	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychosis	Yes	No
			Previous Biopsies	Yes	No			

1. Do you have or have you had a disease, condition, or problem not listed above? Yes No

If yes, please list: _____

2. **WOMEN** are you: Pregnant? Yes, ___ Mos. No Nursing? Yes No Taking birth control pills? Yes No

3. Are you taking Tagamet? Yes No How often?

4. Do you take Antacids? Yes No How often?

5. Are you taking any Herbal Supplements/Medicines? Yes No Which ones _____

6. Do you have any food allergies? Yes No

7. How much sugar is in your diet? None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the the doctor of any change in my health medication.

Patient/Guardian Signature _____ Date _____

Medical History Review (for office use only)

Staff Member: _____ Date: _____ Staff Member: _____ Date: _____

SARUBIN FAMILY DENTAL ASSOCIATES, L.L.C.

Release of Information

Patient(s) Name _____

I authorize release of any information relative to dental treatment received in the office of Sarubin Family Dental Associates.

Signed _____ Date _____

Assignment of Benefits

I hereby authorize payment of group dental benefits, otherwise payable to me, to the named provider for professional services rendered. I understand that I am responsible for all costs of dental treatment.

Signed _____ Date _____

Financial Policy

Welcome to Sarubin Family Dental Associates. Our doctors and staff are glad you have chosen our facility for your oral health needs.

Our goal is to provide our patient's with the optimum dental treatment that is available with today's advanced technology. In doing so it is important that there is clear communication with regard to payment for services rendered.

Payment is due at the time services are rendered.

Sarubin Family Dental Associates are happy to accept "assignment of benefits" from your dental plan carrier for that portion or percentage that we estimate they will cover, with the exception of sedation cases. However, please be informed that you are responsible for your co-payment at the time services are rendered. For any reason your dental plan does not pay within sixty (60) days you are responsible for the full balance.

As you are aware, dental plans do not provide coverage for all dental procedures. Therefore, we have devised the following payment options to allow you to have the most comprehensive dental treatment possible for better oral health.

Payment Options

Cash, check (with valid identification), Visa, Master Card, Discover, American Express and Debit Card

I hereby authorize ERN, LLC and /or it's authorized bank(s) to electronically debit my designated checking account for payment of dental procedures.

Signed _____ Date _____

Unicorn Financial Services - Unicorn is a financial institution that we work with to allow our patients to make payments over a twelve (12) month period at interest free. You complete a short application form, we fax it to Unicorn, if approved, Unicorn pays us and you pay Unicorn.

Unicorn Financial Services -- also has an extended payment plan that allows our patients to make payments over a period of twenty-four to thirty-six months. The interest rate is based on your credit rating and to be determined by Unicorn.

To the extent permitted by applicable law, payments for services that are due and owing after thirty (30) days of an invoice date will be subject to a late charge of \$20.00 per month, or one and one half percent (1 1/2 %) of the delinquent amount per month, plus applicable collection costs (including, but not limited to, reasonable attorney fees, and collection agency fees). The undersigned hereby waives his/her right to assert any applicable statute of limitations as a defense to payment for services rendered and acknowledges that he/she has read and received a copy of this Statement of Responsibility.

I have read the above Financial Policy and Statement of Responsibility and understand my responsibilities.

Signed _____ Date _____

Signed _____ Date _____
Witness