Chart #: *«Chart»*
FOR OFFICE USE ONLY

Patient Information

Patient Name: *«LName», «FName» «MI» («PrefName»)* Date*:* *10/06/2017*
Last, First MI (Preferred Name)

Gender: _____ Birth Date: *«BirthDate»* Family Status: *«FamPos»*

Social Security #: *«SS»* Driver's License #: _____

Phone (Home): *«HPhone»* (Cell): _____ Preferred contact method: _____

Email : _____

Address: *«Street»* *«Street2»*
Street Apartment #

«City» *«State»* *«Zip»*
City State Zip Code

Health Information
Have you ever had any of the following? Please check YES or NO

YES	NO		YES	NO	
☐	☐	Have you ever been told by your Dr. that you need to take antibiotics prior to your Dental appointment?	☐	☐	Alcohol Abuse
			☐	☐	Drug Abuse
			☐	☐	Psychiatric Problems
☐	☐	Congenital Heart Defect	☐	☐	Do you take Fosamax for Osteoporosis?
☐	☐	Artificial Heart Valve			If yes, is it via IV or Oral Tablets? _____
☐	☐	Do you take ANY Blood Thinners?	☐	☐	Surgeries: _____
☐	☐	Heart disease			_____
☐	☐	Heart Murmur or Mitral Valve Prolapse			_____
☐	☐	High Blood pressure	☐	☐	Sleep Apnea?
☐	☐	Pacemaker			If yes, Dr. for treatment: _____
☐	☐	Stroke			***For WOMEN:***
☐	☐	Abnormal Bleeding	☐	☐	Are you Pregnant? If Yes, what week #: _____
☐	☐	Artificial Joints	☐	☐	Are you taking Birth Control?
☐	☐	Asthma			***Dental History:***
☐	☐	Cancer	☐	☐	Have you ever had Gum Disease?
☐	☐	Diabetes	☐	☐	Do your gums bleed?
☐	☐	Dizziness / Loss of Balance	☐	☐	Do you floss daily?
☐	☐	Earaches	☐	☐	Change in bite
☐	☐	Epilepsy	☐	☐	Clenching / Grinding (Day or night?) _____
☐	☐	Glaucoma	☐	☐	Jaw Locking / Catching / Popping / Clicking
☐	☐	Headaches	☐	☐	Neck Pain / Stiffness
☐	☐	Hemophilia	☐	☐	Tired Jaw Muscles
☐	☐	Hepatitis A, B or C?	☐	☐	Do you bite your nails?
☐	☐	HIV (+) / AIDS	☐	☐	Do you chew gum? (Sugar or Sugar Free)?
☐	☐	Kidney Disease	☐	☐	Do you chew on candy or mints?
☐	☐	Lupus	☐	☐	Do you chew tobacco?
☐	☐	Radiation Treatment / Chemotherapy	☐	☐	Do you drink carbonated beverages (i.e. coke)?
☐	☐	Rheumatic Fever	☐	☐	Do you suck on fruits (lemons, limes, etc.)?
☐	☐	Ringing in Ears	☐	☐	Do you smoke?
☐	☐	Shingles / Chicken Pox	☐	☐	**Medications:**
☐	☐	Shingles			Please list all medications below, include all Over the Counter Medications and Supplements :
☐	☐	Sickle Cell Disease			_____
☐	☐	Stomach Ulcers			_____
☐	☐	Thyroid Problems			_____
☐	☐	Tuberculosis			_____
☐	☐	Tumors			_____
☐	☐	Venereal Disease			_____
☐	☐	**Codeine Allergy**			_____
☐	☐	**Latex allergy**			_____
☐	☐	**Penicillin Allergy**			_____
☐	☐	**Sulfa Allergy**			_____
☐	☐	**Any additional allergies?** _____			_____

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

Dental Information

- Date of Last Dental Visit: _____ Reason for this visit: _____
- Previous dental treatment received _____
- Name and Contact information of prior Dentist who rendered treatment: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- On a scale of one to ten, (Ten being the highest), how would you rate your overall dental health?
- On a scale of one to ten (Ten being the highest), how would you rate your teeth?
- Are you happy with your teeth and teeth color?
- Is there anything you would like to change about your teeth?
- Have you ever considered a smile makeover or Invisalign?

Finance Options

- So that we may assist our patients with the finance portion of their visit, we are pleased to offer an interest free financing program through Care Credit. Would you like to apply for your pre-approved (Care Credit) interest free financing program?
  ☐ Yes ☐ No

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

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Shade: _____ Alignment: _____

Dr. Signature_____ Date: _____

Referral Information

Whom may we thank for referring you to our practice?

☐ Patient: _____ ☐ Insurance Company website: _____

☐ Internet ☐ Mailer ☐ Other: _____

Consent 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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay the value of said services to said Doctor, or his assignee, at the time services are rendered. I further agree that the 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.

Insurance: Dental insurance is a contract between you and the insurance company. Despite our best efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill your insurance company on your behalf. *If your insurance company has not made payment within 30 days, the outstanding balance becomes your responsibility.* I fully understand and agree my financial arrangements and obligations with Ruppel Dentistry supersede any/all insurance contracts that either I or Ruppel Dentistry may have signed. I authorize Ruppel Dentistry to send any/all dental information to my insurance company.

Collections: A service charge of (21% per annual) on the unpaid balance as well as $5.00 per month late fee will be charged on all accounts exceeding 7 days past due. If balance is outstanding more than 7 days, patient agrees to pay all fees, including but not limited to: late fees, interest fees, as well as attorney and/or collections fees totaling an additional fee of 50% of outstanding debt. Report to a collection agency may also occur if balance has not been paid after 45 (forty-five) days.

No Shows / Appointment Cancellations: We respectfully request a 48-hour notice if you cannot keep your scheduled appointment. This will allow us not only to serve those patients who are on the waiting list, but will prevent your account from receiving a No Show / Cancellation fee of $35.00 *or up to full visit fee*, depending on the length of the appointment that was not kept. (No Show consists of not showing up for your scheduled appointment or calling less than 48 hours to cancel an appointment.) We do understand that medical or family emergencies do arise, therefore exceptions to this policy will be handled on a case by case basis. Please Note: Patients with **three no show appointments** will be asked to transfer their records to another dentist.

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

_____ _____ Date: _____
Name of Parent or Guardian: (please print)_____Signature of Parent of Guardian

HIPAA

I _____ have read a copy of the Health Insurance Portability and Accountability Act (HIPAA). I understand that if I wish to have a personal copy, one will be provided to me.

Telephone, Email and/or Text Messages:
I grant my permission to you or your assignee(s), to contact my (including leaving messages on my voicemail, email, text, or with an individual answering the phone) related to any of my dental records, dental treatment, account balance, account collection matters, dental appointments, or any other dental matter.

Reminder Emails, Texts, or Cards:
I grant permission to send reminder emails, texts, or postcards for scheduled and/or unscheduled appointments which will state the date, time, and/or type of appointment.

Persons requesting patient information:
I understand that Ruppel Dentistry will not release any dental information such as: necessary treatment, procedure fees, appointment information (including but not limited to; date and time of appointment or reason for the appointment), to any individual who is personally requesting the above information unless I have authorized this office to do so.

Authorization to release information to individuals requesting dental records

I _____, authorize Ruppel Dentistry to release ANY and ALL dental information to the following people. I also understand that Ruppel Dentistry **will not** be held responsible for verifying identification of the individuals listed below.

Name of friend, Family Member or Other:

Name: _____ Relationship: _____
(Please print)

Name: _____ Relationship: _____
(Please print)

_____ Date: _____
Signature of Patient

_____ _____ **Date:** _____
Name of Parent or Guardian (Please print) **Signature of Parent or Guardian**

I understand that by signing this form, I am verifying that I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) and I have read the above office policy and agree to their content.

_____ Date: _____
Signature of Patient

_____ _____ **Date:** _____
Name of Parent or Guardian (Please print) **Signature of Parent or Guardian**