

# Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # \_\_\_\_\_

SS#/SIN \_\_\_\_\_

Date \_\_\_\_\_

## Patient Information (CONFIDENTIAL)

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License# \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

Discover  AMEX

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL INSURANCE?  Yes  No IF YES, COMPLETE THE FOLLOWING:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local# \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group# \_\_\_\_\_ Policy/ID# \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No	
1. Are you under medical treatment now? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you wearing contact lenses? .....	<input type="checkbox"/>	<input type="checkbox"/>	
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you allergic to or have you had any reactions to the following?			
If yes, please explain _____			Local Anesthetics (e.g. Novocain) .....	<input type="checkbox"/>	<input type="checkbox"/>	
3. Are you taking any medication(s) including non-prescription medicine? .....	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics .....	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, what medication(s) are you taking? _____			Sulfa Drugs .....	<input type="checkbox"/>	<input type="checkbox"/>	
4. Have you ever taken Fen-Phen/Redux? .....	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates .....	<input type="checkbox"/>	<input type="checkbox"/>	
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? .....	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives .....	<input type="checkbox"/>	<input type="checkbox"/>	
6. Do you use tobacco? .....	<input type="checkbox"/>	<input type="checkbox"/>	Iodine .....	<input type="checkbox"/>	<input type="checkbox"/>	
7. Do you use controlled substances? .....	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin .....	<input type="checkbox"/>	<input type="checkbox"/>	
8. Do you have or have you had any of the following?			Any Metals (e.g. nickel, mercury, etc.) .....	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	Latex Rubber .....	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Attack .....	<input type="checkbox"/>	<input type="checkbox"/>	Other (please list) _____			
Rheumatic Fever .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
Swollen Ankles .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Women Only:			
Fainting / Seizures .....	<input type="checkbox"/>	<input type="checkbox"/>	a) Are you pregnant or think you may be pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma .....	<input type="checkbox"/>	<input type="checkbox"/>	b) Are you nursing? .....	<input type="checkbox"/>	<input type="checkbox"/>	
Low Blood Pressure .....	<input type="checkbox"/>	<input type="checkbox"/>	c) Are you taking oral contraceptives? .....	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy / Convulsions .....	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No	Yes	No
Leukemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes .....	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases .....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection .....	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever / Allergies .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem .....	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux .....	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker .....	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur .....	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired .....	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia .....	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema .....	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer .....	<input type="checkbox"/>	<input type="checkbox"/>				
Arthritis .....	<input type="checkbox"/>	<input type="checkbox"/>				
Joint Replacement or Implant .....	<input type="checkbox"/>	<input type="checkbox"/>				
Hepatitis / Jaundice .....	<input type="checkbox"/>	<input type="checkbox"/>				
Sexually Transmitted Disease .....	<input type="checkbox"/>	<input type="checkbox"/>				
Stomach Troubles / Ulcers .....	<input type="checkbox"/>	<input type="checkbox"/>				
Osteoporosis .....	<input type="checkbox"/>	<input type="checkbox"/>				

# Patient Dental History

Name of Previous Dentist and Location \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing? .....	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods? .....	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth? .....	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth? .....	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries? .....	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials? .....	<input type="checkbox"/>	<input type="checkbox"/>
Clicking .....	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face) .....	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing .....	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile? .....	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing .....	<input type="checkbox"/>	<input type="checkbox"/>			

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X** \_\_\_\_\_  
Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_  
\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Desert Dental**  
**Kamran Ruintan, D.M.D.**  
**Patient Responsibility Form**

Patient Name: \_\_\_\_\_

Our staff makes every effort to assist you in understanding your dental benefits. However, it is impossible for us to know all the many different insurance plan benefits from one plan to another. Therefore, we are providing this Notice to inform you of the following responsibilities as they relate to benefit coverage and payment responsibilities by the patient and Dr. Kamran Ruintan/Desert Dental.

**Dr. Kamran Ruintan/Desert Dental's Responsibilities:**

- Dr. Kamran Ruintan/Desert Dental is NOT responsible for knowing what services are covered by the patient's insurance plan and is NOT responsible for informing the patient whether a particular service is covered. As a courtesy, we do our best to obtain information about your plan's coverage.
- Dr. Kamran Ruintan/Desert Dental will assist the patient in obtaining payment from his/her insurance company by submitting the necessary insurance claims.

**Patient's Responsibilities:**

- It is the patient's responsibility to know and understand his/her own insurance benefit coverage and limits. The patient is ultimately responsible for payment for all services rendered by Desert Dental at the time of the treatment, and the patient must pay for any services not covered by the patient's insurance company.
- Patients MUST pay their patient portion/copayment at the time of service.
- Patient's may incur, and are responsible for payment of additional charges, if applicable. These charges may include:

- ✓ **Charge for returned checks - \$35**
- ✓ **No Show Fee - \$25**

By signing below, I hereby acknowledge and understand my responsibilities as a patient of Dr. Kamran Ruintan and accept that Dr. Kamran Ruintan/Desert Dental is not responsible for knowing my insurance benefits for services provided.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date

**Notice of Privacy Practices and Patient Consent  
For Use and Disclosure of Protected Health Information**

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE

I **understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I **understand** that Desert Dental may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other used and disclosures of this information without my authorization.

Desert Dental has a detailed document called the '**Notice of Privacy Practices**'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I **understand** that I have the right to read the '**Notice**' before signing this agreement. If I ask, Desert Dental will provide me with the most current **Notice of Privacy Practices**.

My signature below indicates that I have been given the chance to review such copy of the **Notice of Privacy Practices**. My signature means that I agree to allow Desert Dental to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Desert Dental has taken action relying on this consent.

\_\_\_\_\_  
SIGNATURE (Patient or Legal Custodian/Authorized Representative)

\_\_\_\_\_  
Relationship to Patient if signed by another party

**Authorization for Medical/Dental Release**

I **authorize** Desert Dental to speak to the following family members or my personal representative on my behalf:

Family member/Personal Representative

Relationship

phone number

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_