# RAMOS DENTAL CENTER

## Patient Information

Patient name: ______________________________ DOB: __________________

Address: ______________________________City: _____________Zip______

Home phone: ___________Work phone: __________Cell phone:______________

Male __Female ___ Minor ___ Single ___ Married ____ SS#_________________

Employer name: ________________________________________

Employer address: _____________________________________

In the event of an emergency, who should we contact?

Name: ____________________ Relationship: ________Phone# _______________

## Responsible Party

Who is financially responsible for this account?

Name: ________________________Relationship to the patient: _____________

Birthdate: ___________ SS# ______________

Address: _____________________________ Home phone:______________

Cell phone: _____________________ Work phone: _____________________

Employer: _____________________ Employer address: _____________________

Nearest relative not living with you: __________________Phone #______________

Nearest friend not living with you: ___________________Phone #______________

# Insurance Information

Name of insured: ______________________ Relationship to patient: ____________

Insured's birthdate: ______________________ Social Security # ________________

Employer: ___________________________ Occupation ____________________

Insurance company: _________________________________

Group # _____________________ Indentification # _____________________

Insurance company address: __________________________________________

Insurance company phone: ______________________________

Your insurance coverage is a contract between **YOU** and your insurance company. We will gladly submit your claims, however, it is your responsibility to follow-up on any additional information the insurance company may need. Please call the **MEMBER SERVICES** number on the back of your card to obtain the following information:

Deductible amount: $_______ Yearly maximum: $________

Preventative: _________% Basic: _____% Major: ______%

Is preventative subject to deductible? YES NO

Are sealants a covered benefit? YES NO
If yes, at what age limit? ______

How often are the following X-rays allowed:
Panorex/full mouth: _______________ Bite wings: _____________

If you have a secondary insurance carrier, please notify the receptionist.

**I realize that failure to keep this account current, will result in Dr. Ramos being unable to provide additional dental services, except for emergencies. In case of default on payment of this account, I agree to pay collection cost, late fees and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.**

_________________________________________ ____________
Signature of Responsible Party Date

# Health History

Are you allergic to any medications, latex, or metals? _____ If yes, which ones?

________________________________________.

Are you currently taking any medications/blood thinners/Bisphosphonate drugs? _____ If yes, what medications are you taking and for what reasons?

________________________________________________________________________.

Have you ever been told by a health care provider that you need antibiotic pre-medication before dental treatment? ______________.

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? ________

Are you pregnant, nursing or taking birth control pills? __________

Do you have or have you ever had any of the following medical conditions? Please circle if YES

| | | | |
|---|---|---|---|
| Rheumatic Fever | Seizures | Scarlet Fever | Diabetes |
| Heart defect/murmur | Heart Disease | Heart Surgery/Transplant | Pacemaker |
| Artificial Heart Valve | Rheumatism | AIDS/HIV | Joint replacement |
| High Blood Pressure | Low Blood Pressure | Kidney trouble | Stomach ulcers |
| Hepatitis, jaundice | Tuberculosis | Stroke Cancer | Asthma |
| Epilepsy | Lung problems | Anemia | Sinus Trouble |
| Leukemia | Fainting Spells | Sexually Transmitted Disease | Drug Addiction |
| Glaucoma | Abnormal bleeding | Thyroid problems | Blood transfusion |

If you answered "yes" to any of the above conditions/disease, please explain:

________________________________________________________________________

________________________________________________________________________

Have you been hospitalized in the past year? ____________________.

Physicians Name ____________________________ Phone: ______________

To the best of my knowledge, the above questions have been accurately answered.

________________________________________ ________________

Signature Date

## Dental Health History:

1. Are you having any current dental problems or concerns: ________________________________________
2. When was your last dental visit: ____________________
3. When was your last dental cleaning: ____________________
4. How often do you brush your teeth: ____________
5. What texture toothbrush do you use: Soft___ Medium ___ Hard ___
6. Would you be interested in any of our bleaching techniques: Yes __ No __

| | Yes | No |
|---|---|---|
| 7. Do your gums bleed while brushing: | ____ | ___ |
| 8. Do you feel pain in any of your teeth while brushing or flossing? | ____ | ___ |
| 9. Are your teeth sensitive to hot, cold, or sweet foods? | ____ | ___ |
| 10. Have you noticed any loosening of your teeth? | ____ | ___ |
| 11. Do you have any sores in your mouth? | ____ | ___ |
| 12. Have you ever experienced any of the following problems in your jaw? | | |
| a. Clicking | ____ | ___ |
| b. Pain (joint, ear, side of face) | ____ | ___ |
| c. Difficulty in opening or closing | ____ | ___ |
| 13. Have you ever had any head, neck, or jaw injuries? | ____ | ___ |
| 14. Do you have frequent headaches? | ____ | ___ |
| 15. Do you clench or grind your teeth while awake or asleep? | ____ | ___ |
| 16. Have you ever had: | | |
| a. Braces | ____ | ___ |
| b. Oral Surgery | ____ | ___ |
| c. Gum Treatment | ____ | ___ |
| d. Your teeth ground or the bite adjusted | ____ | ___ |
| e. Worn an appliance | ____ | ___ |
| 17. Do you smoke, or use tobacco products (snuff)? | ____ | ___ |
| 18. Do you use any non-prescription drugs or Herbal supplements? | ____ | ___ |
| 19. Do you take weight-loss meds? | ____ | ___ |
| 20. Do you consume grapefruit or grapefruit juice? | ____ | ___ |