PATIENT INFORMATION
(Mr./Mrs./Ms./Dr.) Date: _____

Patient Name: _____

Preferred Name: _____ D.O.B: _____ SS #: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____ General Dentist: _____

Work Phone: _____ Referring Dentist: _____

Cell Phone: _____ Employer: _____

If your dental insurance / secondary insurance is through someone other than yourself:

Policy Holder Name: _____Employer:_____

Policy Holder Address:_____

Policy Holder DOB: Policy Holder SS#:

It is our priority to make your appointment as convenient and pleasant as possible. We will try to advise you of the expected prognosis (outcome), what you may expect of this treatment, as well as the fee owed.

I understand that after Root Canal Treatment my tooth will need a permanent filling and/or a crown within the next six weeks (done by a General Dentist). This is of equal importance for the preservation of the tooth. **Root Canal Treatment fee does not include this service**. I understand that if I wait longer than six weeks, bacteria may re-contaminate the root canal system and jeopardize the treatment prognosis.

I am obligated to R. Rubin Gutarts, D.D.S., M.S. Inc. for payment for services/treatment. Any difference between the fee (standard or contracted) and the amount my insurance pays, is my responsibility.
*Even though it is my responsibility to know my insurance policy, R. Rubin Gutarts, D.D.S., M.S. Inc will help me **estimate** my portion of payment based on the information given by my insurance company. **I understand that this is not a quote,** and understand that the information given by my insurance company prior to treatment may not always be correct. Once my insurance processes the claim correctly, I understand that I may still owe more money if I have initially underpaid for treatment, or that R. Rubin Gutarts, D.D.S., M.S. Inc. will be refunding some of my payment back to me, if I have initially overpaid. My estimated payment is due in full prior to treatment. **I agree that if at any time my account goes to a collection agency (60 days past due) there will be a surcharge of 35% added to my account balance.**
I have read the above and agree to the terms. I authorize the release of any information relative to this claim.
Signature: _____ **Date:** _____

I authorize R. Rubin Gutarts D.D.S., M.S. Inc to submit insurance claims to my insurance company. I authorize payment of any group insurance benefits, otherwise payable to me, to R.Rubin Gutarts D.D.S., M.S. Inc.
Signature: _____ **Date:** _____

HEALTH HISTORY

Primary Physicians name: _____

Are you pregnant: Yes____ No_____ If Yes, Due Date: _____
Are you taking oral contraceptives? _____

Do you have any of the following? (Please check if **yes**)

_____AIDS or HIV	_____DIABETES	_____MITRALVALVE PROLAPSE
_____TMJ	_____KIDNEY DISEASE	_____BLEEDING PROBLEMS
_____CANCER	_____GLAUCOMA	_____JOINT REPLACEMENT
____ HEPATITIS	_____TUBERCULOSIS	_____HEART VALVE REPLACE.
_____ULCER	_____HEART MURMUR	_____HIGHBLOOD PRESSURE
_____HERPES	_____PACEMAKER	_____HEART PROBLEMS
_____ARTHRITIS	_____RHEUMATIC FEVER	_____HYPO/HYPER THYROID

Do you have any **disease, condition, or problem** not listed above? ___Yes ___No
If yes: _____

_____

Please list all current medicines or drugs and doses of each:

_____

_____

_____

_____

Are you taking, or have you ever taken any **bone enhancing medications** such as:

Aredia, Zometa, Bonefos, Fosamax, Actonel, Boniva? _____

Have you had a true allergy to any of the following: (Please check if **yes**)

ANESTHETIC _____	IBUPROFEN _____
CODEINE _____	PENICILLIN _____
LATEX _____	ERYTHROMYCIN _____
ASPIRIN _____	SULFA_____

OTHER ALLERGIES: _____

_____

Do you PREMEDICATE with an antibiotic 1 hour prior to dental appointments due to a specific medical condition? (ex: joint replacement, heart valve issues, etc.)

Yes:____ No:_____

SPECIALIST MEMBER

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NOTICE OF PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

We believe your health information is personal. We keep records of the care and services that you receive at our facility. We are committed to keeping your health information private. Our Notice of Privacy Practices describes potential uses and disclosures of your health information by our practice and outlines your medical privacy rights.

Sign this form below to acknowledge the following:

• I have been offered a copy of the Notice of Privacy Practices for Dr. Rubin Gutarts – R. Rubin Gutarts,DDS, MS, Inc

• I understand that the Notice of Privacy Practices explains how R. Rubin Gutarts, DDS, MS, Inc may use and disclose health information that identifies me.

• I consent to let R. Rubin Gutarts, DDS, MS, Inc. use and disclose health information about me as described in the Notice of Privacy Practices. In doing so, I consent to the release of health information about me to my insurer, other third party payers, and any agents or consultants that help R. Rubin Gutarts, DDS, MS, Inc. receive reimbursement or to assist in my treatment or in its health care operations.

Name (Please print) : _____

Signature:_____ Date: _____

(If patient is a minor)
Parent/Guardian Name: _____

Signature:_____ Date: _____

Please check one:

_____ Do not discuss my medical or payment information with anyone but myself.

_____ List below the name (s) of any individual (s) with whom we may discuss your medical or payment information:

Name	Phone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

*May we leave a message on your answering machine/voice mail? (circle one) Yes No