Ruby Canyon DENTAL

2552 Patterson Road
Grand Junction, CO 81505

(970) 241-1313

Patient Information

Date:

Patient Name:

Last Name First Name MI Preferred Name

Phone:

Cell Number Home Phone Work Phone Ext. Best Time to Call

Social Security # Birth Date

Family Status: ☐ Single ☐ Child ☐ Married ☐ Divorced Gender: ☐ Male ☐ Female

Preferred Appointment Times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐ M ☐ T ☐ W ☐ T ☐ F ☐ S

Address:

Street Apartment #

City State Zipcode Email

Health Information

Date of Last Dental Visit: Reason for This Visit:

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
☐ Allergies
_____
_____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due Date: _____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Codeine Allergy
☐ Penicillin Allergy

LIST MEDICATIONS

_____
_____
_____
_____

- Alcohol/Tobacco Use

Have you ever used Tobacco? ☐ Yes ☐ No How much/long? _____

Have you ever used Alcohol? ☐ Yes ☐ No How much? _____

- Have you ever had any complications following dental treatments? ☐ Yes ☐ No

If yes, please explain: _____

- Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

- Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain: _____

To the best of my knowledge, all 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.

➡ Sign Here: _____

Signature of Patient, Parent or Guardian Date

Referral Information

Whom may we thank for referring you to our practice? _____

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Spouse or Responsible Party Information

The Following is for: ☐ The Patient's Spouse ☐ The Person Responsible for Payment

Name: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Child ☐ Other _____

Phone: _____

Home Phone | Work Phone | Ext. | Best Time to Call | Social Security # | Birth Date

Address: _____

Street | Apartment #

_____

City | State | Zip Code

Employment Information

The Following is for: ☐ The Patient ☐ The Person Responsible for Payment

Employer Name: _____ Occupation: _____

Address: _____

Street | City | State / Zip Code

Insurance Information

Primary

Is Insured a Patient? ☐ Yes ☐ No

Name of Insured: _____

Last Name | First Name | MI

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured SS#: _____

Insured's Employer Name: _____ Insurance Plan Name: _____

Secondary

Is Insured a Patient? ☐ Yes ☐ No

Name of Insured: _____

Last Name | First Name | MI

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured SS#: _____

Insured's Employer Name: _____ Insurance Plan Name: _____

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.

I authorize my insurance company to make payments directly to Ruby Canyon Dental and I understand that I am responsible for any charges not paid or covered by my insurance.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable 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.

I authorize Ruby Canyon Dental to take my photo to use for identification purposes. I also authorize the use of photography or video to be used as a record of my care and may be used for communication with other health care professionals, educational publications, and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

➡ _____

Signature of Patient, Parent or Guardian | Date | Relationship to Patient

➡ _____

Signature of Guarantor of Payment/Responsible Party | Date | Relationship to Patient