

**EL DORADO HILLS COSMETIC & IMPLANT DENTISTRY**  
**JARED W. RUMINSON, D.D.S.**

**Patient Information**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)

Male  Female  Married  Single  Child  Other Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Code

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_ (E-mail) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

**Health Information**

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Stomach Problems              |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Growths             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Anemia _____        | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Neck Surgery          | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Nervous Disorders     | <input type="checkbox"/> Sulfa Allergy                 |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Penicillin Allergy    | <input type="checkbox"/> Tumors                        |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Phen-fen              | <input type="checkbox"/> Ulcers                        |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> HIV                 | <input type="checkbox"/> Pregnancy             |  |
| <input type="checkbox"/> Codeine Allergy     | <input type="checkbox"/> High Blood Pressure | Due date: _____                                |  |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Pre-Med               |  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Radiation Treatment   |  |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Respiratory Problems  | OTHER:   |
| <input type="checkbox"/> Epinephrine Allergy | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> _____                         |
| <input type="checkbox"/> Excessive Bleeding  |  | <input type="checkbox"/> Rheumatism            | <input type="checkbox"/> _____                         |
| <input type="checkbox"/> Fainting            |  | <input type="checkbox"/> Seizures              |  |
|  |  | <input type="checkbox"/> Sinus Problems        |  |

- Have you ever had any complications or been dissatisfied with dental treatment?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- Have you 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: \_\_\_\_\_
- Are you currently taking any medications?  Yes  No If so, please list: \_\_\_\_\_
- Do you smoke or use tobacco?  Yes  No
- Are you aware of clenching or grinding of your teeth?  Yes  No
- Are you unhappy with the appearance of your teeth? Would you like whiter or straighter teeth?  
 If yes, please explain: \_\_\_\_\_

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.

\_\_\_\_\_  
 Signature of patient, parent or guardian Date: \_\_\_\_\_

Updated: _____ by: _____	Updated: _____ by: _____	Updated: _____ by: _____
Updated: _____ by: _____	Updated: _____ by: _____	Updated: _____ by: _____

## Referral Information

Whom may we thank for referring you to our practice? : \_\_\_\_\_

- Another Patient  Another Office  Welcome Wagon  Village Life  Abundant Lifestyles Magazine  Other  
 EDH Telegraph  EDH Chamber of Commerce  Phone Book  Online Directory Service  EDH Sportsclub/Spa

## Responsible Party Information – (If different from Patient)

Name: \_\_\_\_\_  
Last First MI (Preferred Name)

Male  Female  Married  Single  Child  Other Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cell): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City, State Zip Code Phone

## Insurance Information

### Primary

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Plan Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Secondary

Name of Insured: \_\_\_\_\_  
Last First MI

Insured's Birth Date: \_\_\_\_\_ SS #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Plan Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## Consent for Services

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.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days.

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. 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 were instituted hereunder.

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 understand that dental procedures can cause inflammation and/or changes in teeth or nerves and can lead to tooth, mouth, jaw sensitivity and/or infection. It is possible to have irreversible nerve damage from injections and/or dental procedures. Permanent numbness is a possible side effect from dental procedures and/or anesthetics. Dental anesthetic may contain epinephrine and other ingredients that may cause an increase in blood pressure and ultimately death in rare cases. Materials/procedures commonly used in dental offices have been linked to cancer and other health problems.

I authorize you to release my records as required to provide me with the best dental health.

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: \_\_\_\_\_