

Chart # _____ SSN _____ Date _____

Name _____ Nickname _____ Date of Birth _____

Address _____ Telephone _____

Business Address _____ Business Phone _____

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Home Phone _____

Approximate date of last physical examination _____

Patient Name

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you receiving any medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had any major operations? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what? | | |
| 3. Have you ever had a serious accident involving head injuries? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any adverse response to any drugs including penicillin, codeine or dental anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a physician ever informed you that you had: | | |
| 6. A Heart Ailment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. High Blood Pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Respiratory Disease or Tuberculosis (TB)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Rheumatic Fever? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Rheumatism or Arthritis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Artificial Joint Replacement? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Tumors or Growths? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Any Blood Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Any Liver Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Any Kidney Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. A Kidney Transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Any Stomach or Intestinal Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Any Venereal Disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Hepatitis, Yellow Jaundice? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. AIDS or AIDS Related Complex? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have night sweats accompanied by weight loss or cough? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are you on a diet at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you now taking drugs or medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, what? | | |
| 24. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Are you in general good health at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Have any wounds healed slowly or presented other complications? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are you pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Do you have a history of fainting? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Have you ever had any X-ray treatments (other than diagnostic)? | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT DENTAL HISTORY

- | | | |
|--|--------------------------|--------------------------|
| 30. Do you, at present, have any dental complaints or toothaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you have earaches, sinusitis or pain in or near your ears? | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Do you have any unhealed injuries or inflamed areas in or around your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Does any part of your mouth hurt when clenched? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Does your jaw make clicking or popping noises when chewing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you had any bad dental experiences or difficult extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you had prolonged bleeding following cuts, injuries or dental extractions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do your gums bleed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever had instructions on the care of your teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you chew on only one side of your mouth? If so, why? | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you want to keep your natural teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you habitually clench your teeth during the night or day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Is any part of your mouth sore due to pressures or irritants (cold, sweets, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, locate | | |
| 43. When was your last full mouth X-ray taken? _____ Where? _____ | | |
| 44. Any other medical or dental condition that we should be aware of? If yes, explain | <input type="checkbox"/> | <input type="checkbox"/> |
| 45. I have read, understood and, to the best of my knowledge, answered the above questions correctly. | <input type="checkbox"/> | <input type="checkbox"/> |

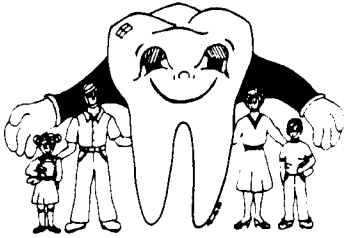
Signature _____ Date _____

1. Signature _____ Date _____

2. Signature _____ Date _____

3. Signature _____ Date _____

HEALTH HISTORY UPDATE



AVENUE B DENTAL GROUP

STEVE RUBISCH, D.D.S.

1460 SOUTH AVENUE B • YUMA, ARIZONA 85364 • (928) 344-3067

PATIENT REGISTRATION

(Please Print)

Marital Status S M W D

Patient Sex M F

Patient's Name: _____

Local Address: _____ City _____ Zip _____

Mailing Address (If different than above): _____ Zip _____

Home Phone #: _____ Cell Phone #: _____ Patient's Birth Date: _____ Age: _____

Patients Employer: _____ Work Phone #: _____

Referral Source: _____ S.S. # _____

RESPONSIBLE PARTY:

Name: MR.
MRS.
DR.
MS. _____

Local Address: _____ City _____ Zip _____

Date of Birth: _____ Social Security Number _____

Phone No. (home) _____ Phone No. (work) _____ Cell Phone _____

Employer: _____

Address: _____ City _____ Zip _____

COMPLETE THIS PORTION ONLY IF YOU HAVE DENTAL INSURANCE

PRIMARY INSURANCE:

Name of Insured: _____

Insurance Company: _____

Name of Employer: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE:

Insurance Company: _____

Name of Employer: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Social Security #: _____

The undersigned agrees, whether he/she signs as a patient or whether or not he/she is insured or is a member of a health maintenance organization, that in consideration of the services rendered to and/or items sold to the patient, he/she hereby individually obligates himself to pay this account upon receipt of the initial bill for the above mentioned services and/or acknowledges that he/she is primarily responsible for payment of the account notwithstanding the existence of other sources of payment, unless previous financial arrangements have been made.

We bill your insurance company as a **courtesy only**. Patient is responsible for charges.

A 1.5% monthly service charge is assessed on ALL balances over 60 days.

Date: _____

(Signature of Patient or Responsible Party)



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FINANCIAL POLICY

Charges for dental services are due and payable at the time services are rendered. In the event other arrangements are made with the office manager, a statement will be mailed to you. Payment is due upon receipt of this statement. If unusual circumstances make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our office manager. This will avoid any misunderstandings and enable you to keep your account with us in good standing. Accounts over 90 days past due will be referred to our collection agency. Such assignment gives the patient or head of household responsibility for the balance and any additional costs incurred in the collection process including, but not limited to, filing fees, attorney fees, and court costs will be the responsibility of head of household or patient. **A service fee of \$25.00 will be added to your account for each check that is returned to us by your bank and in the event your account is turned over for collections.** It is our hope that you will understand that our credit and collection policies are a necessary part of ensuring the financial resources required to maintain the vital health care service for our patients and the community.

If you have health insurance, it should be understood that your policy is a contract between you and your insurance company. It is important that you understand its provisions. We cannot guarantee payment of your claims. You are responsible for the payment of your bill regardless of the status of your insurance claim. If your insurance company pays only a portion of the bill, or rejects your claim entirely, an explanation should be made to you by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation to us. We will gladly bill the insurance company for you, but if after 60 days your insurance has not paid for their estimated portion of your claim, payment will become due by you.

Insurance companies have a schedule of fees which they will pay. Your dental fees may be more or less than the schedule of your insurance company. You are directly responsible to this office for your account regardless of your insurance company's schedule. **It is the patient and guarantors responsibility to know what their insurance carrier will pay and if they have a maximum benefit limit before services are rendered.**

A \$35.00 fee will automatically be added to your account after the patients second (2nd) no-show or re-set without 24 hour notice.

I HAVE READ AND AGREE TO THE ABOVE TERMS AND HEREIN AUTHORIZE AVENUE B DENTAL GROUP TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION REQUIRED TO PROCESS AN INSURANCE CLAIM. FURTHER, I AUTHORIZE MY INSURANCE COMPANY TO MAKE DIRECT PAYMENT TO AVENUE B DENTAL GROUP FOR ALL UNPAID CHARGES.

SIGNATURE _____ DATE _____



AVENUE B DENTAL GROUP

STEVE RUBISCH, D.D.S.

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(520) 344-3067

Name: _____

Date: _____

Conscious Sedation Instructions and Consent Form

Pre-Sedative Instructions:

1. We must know if you have taken any medications for two (2) days prior to the sedation visit.

2. I acknowledge that I am currently taking the following drugs and medications. Including: alcohol, aspirin, birth control, coffee, tea, cigarettes, recreational drugs, and over-the-counter drugs. I understand there are potentially severe consequences of not providing this information to the doctor.

- | | | |
|----------|----------|-----------|
| 1. _____ | 5. _____ | 9. _____ |
| 2. _____ | 6. _____ | 10. _____ |
| 3. _____ | 7. _____ | 11. _____ |
| 4. _____ | 8. _____ | 12. _____ |

3. If you are sick with flu-like symptoms, such as; coughing, sneezing, congestion, fever, sore throat, nausea, rash, etc., the day before the appointment, please call our office as we may have to reschedule the appointment.

4. Do not eat or drink for 8 hours before your appointment.

5. Dental treatment will begin 45 to 60 minutes after the medication has been given.

6. You will need to have someone drive you home after your appointment and to possibly assist you in getting into and out of your vehicle.

7. Your breathing rate may be slowed down during and after treatment. Someone should be available to closely monitor your recovery for 24 hours following treatment.

8. You may experience dizziness, agitation, excitement, drowsiness, nausea or other reactions in response to the medications. These effects may linger for several hours following your treatment.



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Conscious Sedation Instructions and Consent Form Cont'd

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Patients with a complex, medical history, also may be taking multiple medications. Approximately 20% of individuals aged 65 or older, are taking 5 or more prescribed medications. Patients taking 5 medications have a 50% chance of significant drug interaction; for a patient taking 8 medications that likelihood increases to 100%.

For patients with an ASA physical status scope of 3 (that is, a severe systemic disease that is not incapacitating) it is necessary to have a medical consultation with your primary care physician, before anxiolysis by pharmacologic means begins. Administration of anxiolytic medications to a patient with serious or possibly multiple medical conditions can increase operative risk

Because of my medical history, it has been thoroughly explained to me and I completely realize that any surgical procedure, with the use of Sedation, may, therefore, be classified as a risk procedure. The risk involved is defined as a greater possibility of experiencing morbidity (the relative incidence of medical implications), and mortality (the proportion of death to population), during the surgical procedure than that of a person in good health. Those complications which can occur during surgery may involve more than the average amount of post-operative discomfort, increased pain and swelling, and delayed healing. I fully acknowledge that the possible complications have been explained.

I acknowledge and agree to the following:

1. I will not eat or drink anything 8 hours before my appointment (including coffee) except for water to take any medications.
2. I will have a responsible adult drive me to and from my appointment, stay here at the office during my appointment, and stay with me for the rest of the day and night (24 hours) to closely monitor me for my protection and safety.
3. For 24 hours after the procedure, I will not:
 - Drive a vehicle, operate machinery, or power tools.
 - Ingest alcohol, tranquilizers or sleeping pills.
 - Return to work.
 - Make any important decisions.

After reviewing this consent form and initialing every paragraph, I hereby acknowledge that I understand the use of Sedation for my dental procedures. I have had the opportunity to discuss my questions with the Doctor and they have been answered to my satisfaction.

I may request further explanations for the risks involved and possible outcome of the procedure. When the patient is a minor or incompetent to give consent, signature should be of a person authorized to consent for the patient.



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FAMILY DENTISTRY

FACTS YOU SHOULD KNOW ABOUT DENTAL INSURANCE

As an optimum care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

FACT #1: Your dental insurance is based upon a contract made between your employer and an insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or insurance company directly.

FACT #2: Dental insurance benefits differ greatly from general health insurance benefits. Most dental insurance plans offer a maximum benefit of \$1,000 per calendar year. (This incidentally is the same average amount of dental benefit provided 20 years ago.) Therefore, dental insurance is never a pay-all, it is only an aid.

FACT #3: You may receive notification from your insurance company stating that dental fees are "higher than usual and customary." An insurance company surveys a geographic area, calculates an average fee, and then takes 80% of that fee and considers it customary. Included in this survey are discount dental clinics and managed care facilities which bring down the average. Any doctor in private practice will have fees that insurance companies define as higher than "usual and customary."

FACT #4: Many plans tell their participants that they will be covered "up to 80% or up to 100%" but do not clearly specify plan fee schedule allowance, annual maximum or limitations. It is more realistic to expect dental insurance to cover 35% or 65% of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer put in, less the profits of the insurance company.

FACT #5 Many routine dental services are NOT covered by insurance companies.

Regardless of any dental insurance benefits, the patient (responsible party) is ultimately responsible for all charges. We will be happy to submit your claims and do our utmost so that you receive full benefits payable.

Our office sends most insurance claims electronically, however we need a claim form with your information filled out and signed for us to keep on file in case your insurance company does not accept Electronic Claim Submissions. In order to keep our fees as low as possible, your "ESTIMATED" portion is expected on the date of service.

We will do our best to answer your questions regarding insurance, however, our information is limited and it is always best to refer to your employer, handbook or call your insurance company directly.

Please do not hesitate to ask any questions about our office policies.