



Jazriel Cruz, D.D.S.

GENERAL DENTISTRY

2405 Charles Street – Fredericksburg, VA 22401 – (540) 371-7777 – Fax (540) 371-7473

PATIENT INFORMATION

Today's Date _____

Name _____ () Married () Single () Minor / () Male () Female

SS# _____ Driver License # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____

Do you prefer to receive calls at: () Home () Cell () Work () No Preference

Do you give us permission to send you email/text appointment reminders? () YES () NO

Email Address _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Phone (____) _____

Person to contact in case of emergency _____ Phone (____) _____

Whom may we thank you for referring you to us? _____

RESPONSIBLE PARTY

Person Responsible for account () Patient () Guardian () Spouse () Father () Mother

Name of person responsible for account _____ Phone (____) _____

INSURANCE INFORMATION

Insurance Company: _____ Identification #: _____

Name of policy holder: _____ Relationship to patient: _____

Birthdate _____ SS# _____ Phone (____) _____

Name of Employer _____ Address _____

I hereby authorize any of the doctors of dental auxiliaries to proceed with and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that may arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

Signature of Patient or Guardian X _____

Date _____

Eaglesoft Medical History(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local Anesthetics

Do you use controlled substances?

☐ Yes ☐ No

If yes

Other?

☐

If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No						

Have you ever had any serious illness not listed

☐ Yes ☐ No

If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date: _____



Jazriel Cruz, D.D.S.

GENERAL DENTISTRY

FINANCIAL POLICY AND CONSENT FOR TREATMENT

Full payment is due at time of service, unless other arrangements have been made in advance. We accept Visa, MasterCard, Discover, and Care Credit. Dr. Cruz participates with Delta Dental, Anthem Blue Cross Blue Shield, United Concordia, MetLife, Aetna, Dominion Dental, Guardian, Geha, Care First BCBS, Humana, United Healthcare & Cigna PPO. It is your responsibility to alert us of changes in insurance companies or benefits prior to any appointments. Any balances carried over after insurance payments are your responsibility.

****We maintain a 24 hour (business day) cancellation policy for all appointments Monday through Friday. Appointments on Saturdays have a 48 hour (business day) cancellation policy. We charge \$50.00 per appointment cancelled or rescheduled without adequate notice _____ (initials).**

Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. All of our treatment plans are courtesy estimates to the best of our ability. In the event your insurance carrier does not pay as estimated, the balance forward is your responsibility.

Finance charges will be applied to all accounts over 90 days at a monthly rate of 5%. After the account has been 90 days delinquent, the account will be sent to collections. There will be a collection charge of \$35 posted to the account as of the day it is sent to collections. I understand that should this account go to the collections agency, I will be responsible for all reasonable attorney and collection fees.

I authorize Dr. Cruz and staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.

I authorize Dr. Cruz to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in to provide proper care.

I agree to the use of anesthetics and other medication necessary. I fully understand that using anesthetic agents embodies certain risks. I have read and understand the Financial Policy and Consent for Treatment above and agree to the policy and I have received or have been offered a copy of this office's notice of Privacy Practices.

Patient Signature

Date



Jazriel Cruz, D.D.S.

GENERAL DENTISTRY

NOTICE OF PRIVACY PRACTICES

I understand that Jazriel Cruz, DDS may use and disclose my protected health information for purposes of treatment, payment and health care operations. I acknowledge that I have received, or have been offered, a copy of the practice's Notice of Privacy, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my protected health information. As provided in the notice, the terms of the notice may change. To obtain a copy of the current Notice of Privacy, I understand that I can contact the office at 540-371-7777. I understand that I may revoke my consent for your use and disclosure of my protected health information by making a request in writing. I understand that revocation of my consent would not affect any prior consent and that Dr. Cruz may decline to treat me after I have revoked my consent. By signing this form, I consent to your use of my protected health information.

Patient's/Guardian's Signature

Date

Guardians name and relation to patient: _____