Maria E. Cruz, D.D.S.

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First Name_____MI____Last Name_____

Sex: M____F____ Birthdate_____SSN_____

Mailing Adress_____

City_____State_____Zip_____

E-Mail_____Referred By_____

Home Phone _____Business Phone _____

Cell Phone_____Emergency Contact_____

Patient Employer_____Occupation_____

Person Responsible for Account_____

Relationship to Patient_____

In Whose Name is Insurance Policy In_____

Policy Holder Date of Birth_____Policy Holder Employer_____

Policy Holder SSN_____

Spouse Name_____Spouse contact Number_____

Primary Dental Insurance_____Phone_____

Claims Mailing Address_____

Policy Number_____Member ID_____

Secondary Dental Insurance_____Phone_____

Claims Mailing Address_____

Policy Number_____Member ID_____

PATIENT SIGNATURE_____DATE_____

MEDICAL HISTORY

Existing health issues that you may have, or medication you may be taking can have an important interrelationship with the dentistry you will receive.

Primary Care Physician_____ **Phone**_____

Cardiologist_____ **Phone**_____

Last Medical Exam_____ **Reason**_____

Are you under treatment now?_____ **Reason**_____

List all medications you are taking_____

_____

_____

What Pharmacy do you use?_____

Do you HAVE or HAD any of the following medical issues?

____ Hypertension	____ Abnormal Bleeding	____ Chest Pain
____ Hypotension	____ HIV / AIDS	____ Heart Murmur
____ Hepatitis	____ Kidney Disease	____ Mitral Valve Prolapse
____ Diabetes	____ Liver disease	____ Artificial Heart Valve
____ Epilepsy/Seizures	____ Cancer / Tumors	____ Stint / Shunt
____ Asthma	____ Chemotherapy	____ Screws / Pins
____ COPD	____ Radiation Treatment	____ Heart Defect
____ Anemia	____ Stroke	____ Artificial Joint
____ Hemophilia	____ Heart Attack	____ Artificial Bones
____ Auto Immune	____ Pacemaker	____ Cadaver Implant
____ GI Issues	____ Sinus Issues	____ Beta Blockers
____ Osteoporosis	____ Fainting	____ Anxiety
____ Depression	____ Migraines	____ Bone Fusion

DO YOU TAKE BLOOD THINNERS (other than aspirin)? _____ YES _____ NO
DO YOU PREMEDICATE BEFORE DENTISTRY? _____ YES _____ NO
DO YOU TAKE NITROGLYCERIN? _____ YES _____ NO
DO YOU TAKE OSTEOPOROSIS MEDICATION? _____ YES _____ NO

Are you ALLERGIC or SENSITIVE to any of the following?

____ Penicillin	____ Sulfa Drugs	____ Tetracycline	____ Latex
____ Codeine	____ Aspirin	____ Erythromycin	____ NSAIDS
____ Acetaminophen	____ Ibuprofen	____ Dental Anesthetics	____ Keflex
____ Sucralose	____ Metals	____ Clindamycin	____ Other

I acknowledge that I have reviewed ALL questions/alerts and responded accordingly. There are no other medical conditions, medications or allergies that are not listed. I am aware that I must notify the practice of any future changes.

PATIENT SIGNATURE_____ **DATE**_____

DENTAL HISTORY

Previous dentist_____

Date of last dental visit_____**Reason for visit**_____

Do you have a removable full denture or partial? YES ____ NO ____

Have you been treated by a Periodontist (gum specialist)? YES ____ NO ____

Have you ever had braces / Invisalign? YES ____ NO _____

Do you have difficulty chewing your food? YES ____ NO ____

Do your gums bleed when you brush? YES ____ NO ____

Do you smoke, use tobacco or smokeless tobacco? YES ____ NO ____

Do you have problems with dry mouth? YES ____ NO ____

Do you clench or grind your teeth? YES ____ NO ____

Do you have popping in your jaws? YES ____ NO ____

Do you currently wear a night guard? YES ____ NO ____

Have you had a Panoramic film / full mouth x-rays taken within the last 3 years? YES ____ NO ____

FINANCIAL POLICY

I (we) the undersigned authorize treatment by the doctor and supporting staff members.

I (we) understand that patients under the age of 18 must be accompanied by a parent or guardian.

I (we) authorize assignment of insurance benefits where applicable. If payment has not been received from your insurance company within (4) weeks from the date of service, I will accept full responsibility for the payment within (30) days of notification.

I (we) understand and consent that in the event Dr. Cruz is out of the office at any time of my hygiene appointment, the hygienist, which holds an active Maryland license to do so, will perform dental services without her supervision.

I (we) accept full responsibility for any legal or collection agency fees should my account become delinquent.

I (we) understand there will be a charge of ($40.00) for cancelled appointments without (24) hours' notice. Repeated cancelled or no-show appointments may result in dismissal from our practice.

I (we) understand that Dr. Cruz has the right to remove my dental appointment if it has not been confirmed. We make several attempts to reach you regarding your upcoming scheduled appointment. If the appointment is removed. You will be notified.

I (we) understand that if you are more than (10) minutes late for your dental appointment, you may be asked to reschedule.

I (we) understand there will be a (1 ½%) finance charge added to my account if it becomes delinquent.

I (we) understand that there will be a ($30.00) minimum fee charged for any return check.

I grant my permission to you or your assignee to contact me to discuss this statement or my treatment.

Patient Name
(Print)_____

Patient Name
(Signature)_____

Guardian (if under age of 18)_____

Date_____

HIPPA PRIVACY FORM 2

Maria E. Cruz, D.D.S.

Acknowledgement of Receipt of Notice of Privacy Practices

PURPOSE: This form is used to obtain acknowledgement of receipt of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name (Print)_____

Patient Name (Signature)_____

Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- **Individual refused to sign.**
- **Communication barriers prohibited obtaining the acknowledgement.**
- **An emergency prevented us from obtaining acknowledgement.**
- **Other (Specify)_____**