RELAXED DENTISTRY
Ruben D. Cueller DDS
14631 Lee Hwy. #305
Centreville, VA 20121
(703)830-2256

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

E-mail Address: _____ May we contact you by e-mail ☐ Yes ☐ No

Phone (Home): _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

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
- ☐ Allergy Codeine
- ☐ Allergy Penicillin
- ☐ Allergy Latex
- ☐ Allergy Metals
- ☐ Allergy Rubber
- ☐ Allergy Other

_____
_____
_____

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusions
- ☐ Breathing Difficulties
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chemotherapy
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Coronary artery disease
- ☐ Diabetes
- ☐ Dizziness
- ☐ Earaches/ringing in ears
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fever Blister/Cold Sores
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Ache
- ☐ Head Injuries
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart & Valve defects
- ☐ Hepatitis
  - ☐ A
  - ☐ B
  - ☐ C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapsed
- ☐ Psychiatric Care
- ☐ Nervous Disorders
- ☐ Oral Cancer/Tumor
- ☐ Pacemaker
- ☐ Prosthetic Heart
- ☐ Prosthetic Joint(s)
- ☐ **Pregnancy**
  Due date:_____
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Severe Headaches
- ☐ Sexually Transmitted Disease
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Urinate frequently
- ☐ Venereal Disease

OTHER:
- ☐ _____
- ☐ _____

- 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 Date of last complete exam?_____
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any medications at this time? ☐ Yes ☐ No

Medication	**Dosage**	**How Often**	**How Long**

Patient Name: _____ **Date:** _____

Do you use tobacco in any form? ☐ Yes ☐ No
If yes, how much? _____ How Long? ___

Have you ever had an allergic reaction to medication/anesthetic? ☐ Yes ☐ No
If yes, what medication(s) _____
What kind of reaction did you have? _____

- Have you ever had any serious trouble associated with dental treatment/surgery/extraction? ☐ Yes ☐ No
If yes please explain? _____

- Have you ever had any complications following dental treatment?
If yes, please explain: _____

- Have you ever had an unusual reaction to dental anesthetic? ☐ Yes ☐ No
If yes please explain _____

Nearest relative to contact in case of emergency: _____ Phone _____

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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

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

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

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 Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Patient Name: _____ **Date:** _____

Consent for Dental Services/ Examination

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.

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, 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 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.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Insurance Consent

In order for us to help prepare your insurance forms and assist in making collections from insurance companies. To reimburse you or your account, we will need the following authorizations: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials. I have been informed, **Relaxed Dentistry** will bill my Insurance on my behalf, so I may be reimbursed according to my benefit plan, unless prohibited by law, or the treating dentist has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my claims:

X_____

Signature of Responsible Party/Parent or Guardian