Maria E. Cruz, D.D.S.

31413 Winterplace Parkway, Suite 101
Salisbury, Maryland 21804
www.rjmccanndmd.com

First Name_____ MI____ Last_____

Sex: M___ F___ Birthdate_____ SS#_____

Mailing Address_____

City_____ State_____ Zip_____ Home phone_____

Business Phone_____ Cell Phone_____

E-mail Address_____

Name, Phone # of closest relative **NOT** living with you_____

Patient Employed by_____ Occupation_____

Person Responsible for Account_____ Relationship to Patient_____

In Whose Name is Insurance Policy_____ Date of Birth of Ins. Holder_____

SS# of Ins. Holder_____ Employed by_____ Bus. Phone_____

Spouse Name_____ Spouse Bus.Phone_____

Primary Dental Insurance Co._____ Phone_____

Address_____ Policy No._____ Group No._____

Secondary Dental Insurance Co._____ Phone_____

How were you referred to our office? _____

Patient's Signature_____ Date_____

Parent's Signature_____ Date_____

(please turn over)

Medical History

Although dental personnel primarily treat the areas 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.

Name of Physician_____ Phone_____

Last Medical Exam_____ Reason_____

Are you under medical treatment now? _____ Reason_____

Please list any medications or prescriptions you may be taking_____

_____

_____

What Pharmacy do you use_____

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

Y N Hypertension
Y N Hypotension
Y N Hepatitis
Y N Diabetes
Y N Epilepsy/Seizures
Y N Asthma
Y N Anemia
Y N Hemophilia
Y N Take Nitroglycerin
Y N Other_____

Y N Abnormal Bleeding
Y N HIV/AIDS
Y N Kidney Disease
Y N Liver Disease
Y N Cancer/Tumors
Y N Chemotherapy
Y N Radiation Treatment
Y N Stroke
Y N Take Blood Thinners

Y N Heart Attack
Y N Chest Pain
Y N Heart Murmur
Y N Pacemaker
Y N Mitral Valve Prolapse
Y N Artificial Heart Valve
Y N Congenital Heart Defect
Y N Artificial Bones/Joints
Y N Premedicate before dentistry

Are you allergic or sensitive to any of the following drugs or materials?

Y N Penicillin
Y N Codeine
Y N Acetaminophen

Y N Sulfa Drugs
Y N Aspirin
Y N Ibuprofen

Y N Tetracycline
Y N Erythromycin
Y N Dental Anesthetics

Y N Latex
Y N NSAIDS
Y N Other_____

Dental History

Date of last dental visit_____ Reason for visit_____

Do you have removable full or partial dentures?	Y	N
Have you ever been treated by a Periodontist (gum specialist)?	Y	N
Have you ever been treated by an Orthodontist (braces)?	Y	N
Do you have difficulty chewing your food?	Y	N
Do your gums bleed when you brush?	Y	N
Do you smoke, use tobacco products, or smokeless tobacco?	Y	N
Do you have problems with dry mouth (xerostomia)?	Y	N
Do you clench or grind your teeth frequently?	Y	N
Do you have clicking or popping with your jaws (TMJ/TMD)?	Y	N
Was a panoramic or full mouth radiograph taken within the last three years	Y	N

MARIA E. CRUZ, D.D.S.
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OUR OFFICE POLICIES

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

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

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

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

I (we) assume full responsibility for the balance of charges not covered by insurance company and agree to pay my estimated portion of the charges at the time services are rendered.

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

I (we) understand there may be a minimum charge of $30.00 for broken appointments without 48 hours' notice.

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

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

Patient Signature _____ Date _____

Parent Signature _____ Date _____

HIPAA 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 our Notice 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.

_____
{Please Print Your Name as well as your minor children}

_____

_____
{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)_____