RUBINCHIK COHEN

Dale W. Rubinchik, D.D.S., Inc. ~ Jay N. Cohen, D.D.S.
Alec J. Temlock, D.M.D. ~ Evan Brown D.D.S..
902 Woodside Road, Redwood City, CA 94061
Phone: (650) 365-8982 Fax (650) 365-8928 Email: contact@redwoodcitydentistry.com

Patient Information

Name: _____ Date: _____
(Last) (First) (MI)

Address: Street: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ Ext: _____ Pager: _____
Cell: _____ Email: _____

Social Security #: _____ Birth Date: _____

☐ Male ☐ Female ☐ Married ☐ Domestic Partner ☐ Single ☐ Child ☐ Other:

_____

Health Information

Date of last dental visit: _____ Reason for today's visit: _____

Have you ever had or do you take any of the following? Please check Yes (Y) box or No (N) box:

Y N	Y N	Y N	Y N
☐ ☐ AIDS	☐ ☐Excessive Bleeding	☐ ☐ Pacemaker	☐ ☐ **Codeine Allergy**
☐ ☐ Allergies _____		☐ ☐ Fainting	☐ ☐ Premedication (Type) ☐ ☐
Penicillin Allergy			
_____	☐ ☐ Glaucoma	_____	☐ ☐ **Pregnant**
☐ ☐ Anemia	☐ ☐ Growths	☐ ☐Radiation Treatment	Due date: _____
☐ ☐ Arthritis	☐ ☐ Hay Fever	☐ ☐Respiratory Problems	☐ ☐ **Phen-Fen User**
☐ ☐ Artificial Joints	☐ ☐Head Injuries	☐ ☐ Rheumatic Fever	☐ ☐ **Tobacco User**
☐ ☐ Asthma	☐ ☐ Heart Disease	☐ ☐ Rheumatism	☐ Current
☐ ☐ Biphosphonates (Type)	☐ ☐ Heart Murmur	☐ ☐ Sinus Problems	How Much?: _____
_____	☐ ☐ Hepatitis	☐ ☐Stomach Problems	☐ Quit
☐ ☐ Blood Disease	☐ ☐High Blood Pressure	☐ ☐ Stroke	When: _____
☐ ☐ Blood Thinner (Type)	☐ ☐Jaundice	☐ ☐Tuberculosis	☐ ☐ **Latex Allergy**
_____	☐ ☐ Kidney Disease	☐ ☐ Tumors	
☐ ☐ Cancer	☐ ☐ Liver Disease	☐ ☐ Ulcers	
☐ ☐ Diabetes	☐ ☐ Lyme Disease	☐ ☐ Venereal Disease	~~~~~~~~~~~~~~~~~~~~~~~~~
☐ ☐ Dizziness	☐ ☐ Mental Disorders		**Height**: _____
☐ ☐ Epilepsy	☐ ☐ Nervous Disorders		**Weight:** _____

- ***Have you ever had any complications following dental treatment?*** ☐ Yes ☐ No
  If yes, please explain: _____
- ***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
  Name of Physician: _____ Phone: _____
- ***Do you have any health problems that need further clarification?*** ☐ Yes ☐ No
  If yes, please explain: _____

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.

_____ _____
Signature of patient, parent or guardian Date

Referral Information

How were you referred to our practice? ☐ Another Patient (Friend or Relative) Name of Person: _____

☐ Dental Office ☐ Yellow Pages ☐ Coupon ☐ Insurance Provider ☐ Other:

Spouse or Responsible Party Information

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

Name: _____
(Last) (First) (MI)

Address: Street: _____ Apt #: _____
City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ Credit Card #: _____ Exp.: _____

Cell: _____ Social Security #: _____ Birth Date: _____ Driver's License #: _____

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

_____

In Case of an Emergency Information

In case of an emergency please contact the following:

Contact Person's Name: _____ Relation: _____

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

Address: _____
Street City State Zip Code

Employment Information

The following is for ☐ the patient ☐ the person responsible for payment

Employer's Name: _____ Occupation: _____ Phone #: _____

Address: _____
Street City State Zip Code

Consent for Services

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 most dental services furnished are charged directly to the insurance company. The patient is personally responsible for their patient portion (co-pay) of dental services and for dental services that their insurance company does not cover. This office will prepare the patient's insurance forms, 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 1 ½% per month (18% per year) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied.

I also understand that if my balance is delinquent, this office reserves the right to bill by credit card for the balance.

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay the reasonable value of services to the Doctor, or his assignee at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of services shall be as billed unless objected to by me, in writing, within the time of 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.

This office reserves the right to charge $100.00 for appointments cancelled or broken without 2-business days advanced notice.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

Dental Insurance Information

Our office does not accept HMO plans

Primary Dental Insurance

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

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: _____

_____ Phone #: _____

Secondary Dental Insurance

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

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: _____

_____ Phone #: _____

Office Policies

DAY OF SERVICE PAYENT DUE: (EFFECTIVE IMMEDIATELY)

We are making every effort to keep the cost of our dental services affordable for you, the valued patients of our dental practice. Due to the ever-increasing costs of postage and the time-consuming activities of printing, stuffing and collating statements, it has become quite costly to send statements at month's end. **We will now require that our patients pay for their dental treatment at the time that services are rendered. If you have dental insurance your patient portion (co-pay) will be due at the time of visit.** If you need to arrange a payment plan, please do not hesitate to let us know. We will do everything to accommodate you. Besides cash and check, we also accept VISA, MasterCard, American Express and CareCredit as other methods of payment.

INSURANCE BILLING:

As a courtesy to you, we will be glad to send your insurance claim to your insurance company directly. Our office will be collecting the patient's portion (co-pay) at the conclusion of each visit, for any basic or major work performed at this office. (i.e., Fillings, Crowns, Bridges, Extractions, etc.) **It will be YOUR RESPONSIBILITY to be aware of insurance changes, coverage, maximum benefits per calendar and annual deductibles. Any amount not covered by insurance is the patient's responsibility.**

CANCELLATION POLICY:

We require at least 2-business days notice for canceling or rescheduling of appointments. We cannot schedule treatment for other patients in need of dental care when an appointment is broken with insufficient notice. The doctor's and the staff's time is reserved for your dental appointment. **You will be charged $100.00 if 2-business days notice is not given.** Please make every effort to give us 2-business days notice prior to breaking a scheduled appointment to avoid this fee.

FINANCE CHARGES:

A finance charge of 1.5% per month (18% annual percentage rate) will be assessed for accounts that are not paid within 90 days after the completion of any dental treatment. We will be glad to make appropriate financial arrangements with you so that your account can be paid off in a timely manner to avoid finance charges.

ACCEPTANCE:

I accept these office policies and understand how my dental account will be billed. I understand that I am financially responsible for my dental treatment provided to me by the office of Dr. Rubinchik and Dr. Cohen. I hereby authorize the doctor and dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient's Signature: _____ **Date:** _____

Parent or Guardian's Signature: _____ **Date:** _____