Bob Ruwwe Jr., DDS, PC

Welcome to Our Office - Tell Us About Yourself

Name: _____
Last First MI Title
Preferred Name: _____ ☐ Male ☐ Female
Address: _____ City _____ State _____ ZIP_____
SSN: _____ DOB: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail Address: _____
Employer: _____ Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner
How did you hear about our office? _____
Do you prefer to be contacted for appointment confirmation via e-mail, text or phone? ***(Please circle preference)***

Insurance – Primary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Insurance – Secondary

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Bob Ruwwe Jr., DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. In the event legal actions should occur, I would be liable for any and all court costs and collection fees.

Responsible Party Signature: _____
Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

Bob Ruwwe Jr., DDS, PC

Medical History

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name: _____
Physician's Phone: _____
Date of last visit: _____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: _____
Have you ever had any surgical procedures? ❑ Yes ❑ No
Please list each one: _____
Have you ever had a serious head or neck injury? ❑ Yes ❑ No
Are you taking any medications? ❑ Yes ❑ No
Please list each one: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ❑ Yes ❑ No
Are you on a special diet? ❑ Yes ❑ No
Do you use tobacco or any recreational drugs? ❑ Yes ❑ No
If Yes please list: _____

Yes	No	If Female, Please Answer
☐	❑	Are you taking Birth Control Pills?
☐	❑	Are you pregnant? If so, # of Weeks_____
☐	❑	Are you nursing?

Yes	No	Allergies	Yes	No	Allergies
☐	☐	Aspirin	☐	☐	Codeine
☐	☐	Metal	☐	☐	Sulfa Drugs
☐	☐	Penicillin	☐	☐	Acrylic
☐	☐	Latex	☐	☐	Local Anesthetics
☐	☐	Other_____			

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

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
☐	☐	Stroke	☐	☐	Tonsillitis	☐	☐	Ulcers
☐	☐	Swelling of Limbs	☐	☐	Tuberculosis	☐	☐	Venereal Disease
☐	☐	Thyroid Disease	☐	☐	Tumors or Growths	☐	☐	Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes please list: _____

Nearest relative not living with you:

Name: _____ Relationship: _____

Address: _____ Phone: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____Date: _____

PATIENT COMMUNICATIONS (HIPPA)

By Law, without your authorization, Dr. Ruwwe or his staff are unable to communicate with your spouse, adult children, parents (if you are over age 18) or caregivers.

Dr. Ruwwe or his staff may need to communicate with your family or caregivers to make appointments, confirm appointments, discuss treatment needed or performed, and account or financial information. This includes making payments.

Please indicate below the names of individuals who we may communicate with regarding your appointments, medical/dental information, or account information. **If you do not wish to allow us to discuss any of your information with anyone other than yourself, please leave blank and sign to validate.**

My Spouse_____

My Adult Children_____

My Parents_____

My Caregiver_____

Other_____

Date: ___/___/____ Signature_____