

Bob Ruwwe Jr., DDS, PC

Welcome to our office- Tell us about yourself

Full Legal Name: _____

Preferred Name: _____

Responsible Party: ___ Self ___ Other: _____

Address: _____ City _____
State _____ ZIP _____

Home Phone: _____ Work _____ Cell _____

Our office usually sends text reminders, but do you prefer to be notified via: ___ text
___ phone or ___ email

E-mail: _____

Marital Status: ___ Unknown ___ Divorced ___ Married ___ Separated ___ Single ___ Widowed

DOB: _____ SSN: _____ Gender _____

Employer: _____ Occupation _____

How did you hear about our office? _____

Primary Dental Insurance

Name of the Policy Holder: _____, DOB _____, SSN/ID _____

Employer _____, Insurance Company Name _____,

Group # _____

Relationship to Patient: _____

Secondary Dental Insurance

Name of the Policy Holder: _____, DOB _____, SSN/ID _____

Employer _____, Insurance Company Name _____

Group # _____

Relationship to Patient: _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

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

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you taking Birth Control Pills? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| | | If so, # of Weeks _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing? |

Yes No Allergies

- | | | |
|--------------------------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Yes No Allergies

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs |
| <input type="checkbox"/> | <input type="checkbox"/> | Acrylic |
| <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics |

Yes No Conditions

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS/HIV Positive |
| <input type="checkbox"/> | <input type="checkbox"/> | Alzheimer's Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Anaphylaxis |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis/Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Heart Valve |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial Joint |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Breathing Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains |
| <input type="checkbox"/> | <input type="checkbox"/> | Cold Sores/Fever Blisters |
| <input type="checkbox"/> | <input type="checkbox"/> | Cortisone Medicine |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Addiction |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |

Yes No Conditions

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or Seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells/Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack/Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble/Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis A |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives or Rash |
| <input type="checkbox"/> | <input type="checkbox"/> | Hypoglycemia |

Yes No Conditions

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular Heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in Jaw Joints |
| <input type="checkbox"/> | <input type="checkbox"/> | Parathyroid Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Care |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation Treatments |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Renal Dialysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatism |
| <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Shingles |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach/Intestinal Disease |

Yes No Conditions

- ☐ ☐ Stroke
☐ ☐ Swelling of Limbs
☐ ☐ Thyroid Disease

Yes No Conditions

- ☐ ☐ Tonsillitis
☐ ☐ Tuberculosis
☐ ☐ Tumors or Growths

Yes No Conditions

- ☐ ☐ Ulcers
☐ ☐ Venereal Disease
☐ ☐ 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: _____

Bob Ruwwe Jr., DDS, PC

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 any of your 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.

Spouse _____

Adult Children _____

Parents _____

Caregiver _____

Other _____

Signature _____ **Date** _____

Financial, Assignment and Release

I understand that I am financially responsible for all charges for myself and/or any dependents. This includes a billing fee of \$1.50, per month, for accounts that are over thirty (30) days old. If insured, I assign directly to Bob Ruwwe Jr., DDS, all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment 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. collection fees and attorney fees.

Signature _____ **Date** _____

Consent to Treat

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

Signature _____ **Date** _____

I understand that the information that I have verbally 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** _____