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_____
Employer_____, Insurance Company Name_____,
Group #_____

Relationship to Patient:_____

Secondary Dental Insurance

Name of the Policy Holder:_____ ,DOB_____, SSN_____

Employer_____,Insurance Company Name_____,
Group #_____

Relationship to Patient:_____

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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
❑	❑	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: _____

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**_____

Assignment and Release

I understand that I am financially responsible for all charges for myself and/or any dependents. 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.

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** _____