Jon A. Ruel, DMD 21 King Charles Drive Portsmouth, RI 02871 401.683.5990

Patient Registration

Please complete each question, signature required at X's

Patient Information Date___/___/___

Patient's Name____
Last First Middle Preferred

Address____
Street City State Zip

Home Phone #_(___)___________**Cell #**(____)___________OK to receive Text?____**Email**_____________________

Date of Birth____/____/___**Social Security #**__________________ **OR Drivers Lic #**________________________**State**_____

*If patient is a minor, Parents' or Guardians' name____

Employer_______________________________**Work Phone #**__(___)________________________**Ext.**____________

May we call you at work? ☐ **Yes** ☐ **No** **Best time to call**_____________**Best Tel # to call**______________________

Who may we thank for referring you to our office?____

Responsible Party Information

Name of Person Financially Responsible for Account____
Last First Middle

Responsible Party's Address____
Street City State Zip

Responsible Party's Home Phone #___(___)____________Work Phone #___(___)___________________

Responsible Party's Social Security #___________________Date of Birth___/___/___Relation to Patient______________________

Responsible Party's Employer____

Insurance Information

Name of Insurance Cardholder____**Cardholder's Date of Birth**__/___/____

Dental Insurance Co.________________Insurance Cardholder's Employer________________Insured's ID #___________________

*Do you have more than 1 dental insurance coverage? ☐ Yes ☐ No (If yes, please complete below)

Consent to Release of Information to Insurance Co.

X **Signature** (Parent's signature if patient is a minor)____

Consent to Jon A Ruel, DMD 's Financial & Appointment Policy

In an effort to hold down fees, payment is required at the time of service. If you have dental insurance, we will submit a claim on your behalf for direct reimbursement to you. Please remember that we try to help you understand and to maximize your insurance benefits, but dental insurance is a contract between the patient, the employer and the insurance company. Ultimately, the patient is financially responsible for all treatment rendered.

As a courtesy, Jon A Ruel, DMD requires 48 hours notice for any appointment change or cancellation to avoid an office visit fee.

X **Signature** (Parent's signature if patient is a minor)____

Revised 10/05/10 cmc

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Patient Medical History

Physician's Name____Date of last Medical Check Up___/__/__

Physician's Address____Physician's Phone #_(___)_________________________

1. Are you under medical treatment now? ☐ Yes ☐ No
   If yes, for what?____
2. Do you currently have any medications prescribed for you? ☐ Yes ☐ No
   If yes, please list all medications, vitamins and supplements_________________________________
   ____
3. Have you ever had any major operations? ☐ Yes ☐ No
   If yes, what_______________________________________When?_____________________________
4. Have you had any wounds that healed slowly? ☐ Yes ☐ No
5. Have you had any adverse reactions to any medications, foods, or materials? ☐ Yes ☐ No
   If yes, please list all items____
6. Are you currently in good health? ☐ Yes ☐ No
7. For Women: Are you, or is there a possibility you may currently be pregnant? ☐ Yes ☐ No
8. Are you currently taking any medications to treat Osteoporosis? ☐ Yes How long?_____ ☐ No
9. Do you use any tobacco products? ☐ Yes ☐ No

Has your physician ever informed you that you have or had:

Condition	Yes	No	Condition	Yes	No
Allergies/Hay Fever	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Latex Allergy	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Metal Allergies	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	Mental Disorders	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Nervous Disorders	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Cancer/Tumors	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Clotting Disorder	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Dizziness/Fainting	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
Head Injuries	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No	TMD	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Murmur/ MVP	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Other ***	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	***Please list_________________________		
Jaundice/Liver Disease	☐ Yes	☐ No	___________________________________		

Dental History

What is your main dental concern?____

When was your last Dental Exam?_________________Last X-rays?___________________Last Cleaning?____________________

Have you had Orthodontic Treatment? ☐ Yes ☐ No

Have you had Periodontal Treatment? ☐ Yes ☐ No

Do you clench or grind your teeth? ☐ Yes ☐ No………Daytime?____Nighttime?__________

Do you have ear pain, sore muscles? ☐ Yes ☐ No………Do you awaken with headaches?_____

Are you apprehensive about seeing a dentist?☐ Yes ☐ No………Why?___________________________

Emergency Information

Name of nearest relative not living with you_______________________________________Phone#_(____)___________________

_________________________Phone#_(____)___________________

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CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:____

PLEASE PRINT

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information for treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Jon A. Ruel, DMD

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we will decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information for treatment, payment activities and health care operations.

Patient Signature:____Date:_______________________

Or; if this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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PAYMENT POLICY

Thank you for choosing Jon A. Ruel, DMD as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best services available. To help reduce administrative costs and keep our fees to you as low as possible, we require payments to be made at the time that you (or your family members) receive treatment. Please indicate below the method of payment you intend to use.

A NOTE FOR PATIENTS WITH DENTAL INSURANCE

Jon A. Ruel, DMD is not a participating provider of any insurance plans with the exception of UCC ADDP for Active Duty Military Members.
As a courtesy, the staff of Jon A. Ruel, DMD will submit your dental claims on your behalf. All insurance benefits will be paid directly to you.

MY PREFERRED PAYMENT OPTION IS:

_________CASH

_________CHECK

_________MAJOR CREDIT CARD (VISA , MASTER CARD, AMEX ONLY)

ACCEPTANCE AGREEMENT

I understand and agree with the above financial policy. I further understand that I am responsible for **ALL** fees, regardless of insurance coverage.

Patient/Responsible Party: ____
PLEASE PRINT NAME

____
PLEASE SIGN

____
DATE