Ocean Dental Care
Trina Ruchelman, DMD

2120 Route 70 • Manchester, NJ 08759
732-408-5260 | OceanDentalCareNJ.com

New Patient Registration

Patient information

Today's date

Patient name

Date of birth

Social Security number

Gender (M / F)

Marital status

Email address

Street address

City

State

ZIP code

Home phone

Cell phone

Preferred phone contact (circle one): Home / Cell / Work

Employment and spouse

Place of employment

Work phone

Extension

Spouse's name

Date of birth

Dental insurance (if applicable)

Dental insurance company

ID number

Name of individual on insurance card

Social Security number

Relationship to individual

Date of birth

Referral information

Whom may we thank for referring you to our office?

If advertisement, please list

Ocean Dental Care
Trina Ruchelman, DMD

2120 Route 70 • Manchester, NJ 08759
732-408-5260 | OceanDentalCareNJ.com

Adult Medical & Dental History

Name _____ Account number _____ Social Security number _____

Date of birth _____ Sex (F / M) _____ Height _____ Weight _____

Race _____ Ethnicity _____ Language preference _____

General health (circle one): Excellent / Good / Fair

Physician name _____ Date of last physical _____

Medical history and medications

Circle Y or N: Daily aspirin? Y / N Coumadin, Plavix or other blood thinner? Y / N

Steroids or cortisone in the past year? Y / N Other medications? Y / N

List medications _____

Check all that apply:

- ☐ Abnormal blood pressure ____ / ____
- ☐ Anemia / blood disorders
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting spells
- ☐ Glaucoma
- ☐ Heart condition
- ☐ Heart surgery
- ☐ Hepatitis
- ☐ HIV
- ☐ Hospitalizations (surgery or overnight)
- ☐ Prescription diet pills
- ☐ Prolonged bleeding
- ☐ Prosthetic joint replacement
- ☐ Rheumatic fever
- ☐ Sexually transmitted disease
- ☐ Sinus trouble
- ☐ Stroke
- ☐ Tuberculosis / lung disease
- ☐ Ulcers
- ☐ Other _____

Allergies (check all that apply):

- ☐ Codeine
- ☐ Novocaine
- ☐ Jewelry / metal
- ☐ Penicillin
- ☐ Latex
- ☐ Other _____

Women: Are you pregnant? Y / N If yes, weeks: _____ OB/GYN: _____

Dental health

Date of last dental exam _____ Date of last dental cleaning _____

How often do you brush? _____ Gums bleed when brushing? Y / N

How often do you floss? _____ Do you smoke? Y / N If yes, how much? _____

Toothbrush (circle one): Soft / Medium / Hard

- ☐ Bleeding / tender gums
- ☐ Clench / grind teeth
- ☐ Gag easily
- ☐ Jaw / TMJ pain
- ☐ Sensitive teeth (hot/cold/sweets)
- ☐ Wear dentures
- ☐ Wear partials
- ☐ Wear nightguard
- ☐ Other _____

Examination and X-rays: I understand that examination visits may require radiographs and diagnostic photos to complete the examination, diagnosis and treatment plan.

Signature _____ Date _____

Ocean Dental Care
Trina Ruchelman, DMD

2120 Route 70 • Manchester, NJ 08759
732-408-5260 | OceanDentalCareNJ.com

Financial & Dental Insurance Policy

We are committed to providing you with the best possible care. To accomplish this, we need your cooperation. Please review our financial policy.

Payment for services

Payment is due at the time services are rendered, unless payment arrangements have been made in advance with our office manager.

Dental insurance

Ocean Dental Care is an out-of-network provider with all dental insurance companies. Your insurance policy is a contract between you and your insurance company. Our out-of-network status does not necessarily mean your treatment is not a covered service. Benefits depend on your individual plan.

After payment for treatment, we will provide a receipt for you to submit to your insurance company, or we will be happy to submit the claim for you. Your insurance company will directly reimburse you for any covered services, as applicable under your plan.

You are responsible for services not covered or denied by your insurance company. Some insurance companies approve and pay only a portion of our fees. Our relationship is with you, our patient, not with your insurance company. All charges are your responsibility and are payable when services are rendered.

Returned checks and appointments

A **$50 fee** will be charged for returned checks.

We understand that appointment cancellations are often unavoidable. We ask for 24 hours' notice before canceling or rescheduling an appointment when possible. We reserve the right to charge a **$35 cancellation fee** for a missed appointment.

We are here to assist you with your account. Please do not hesitate to ask us any questions.

I have read the above and agree with the contents.

Patient name (print)

Patient signature

Date

Ocean Dental Care
Trina Ruchelman, DMD

2120 Route 70 • Manchester, NJ 08759
732-408-5260 | OceanDentalCareNJ.com

Acknowledgment of Privacy Notice

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient name (print)

Signature

Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)

Other details

Additional notes

Ocean Dental Care • Dr. Trina Ruchelman
2120 Route 70, Manchester, NJ 08759
Phone: 732-408-5260 | Fax: 732-408-5267

Ocean Dental Care
Trina Ruchelman, DMD

2120 Route 70 • Manchester, NJ 08759
732-408-5260 | OceanDentalCareNJ.com

Patient Disclosure Information

Federal law requires Ocean Dental Care, Trina Ruchelman, DMD, to give patients a Notice of Privacy Practices and make a good-faith attempt to obtain written acknowledgment of receipt. By signing this form, you acknowledge receipt of the Notice and completion of the patient disclosure information below.

Communication preferences

I wish to be contacted in the following manner (check all that apply):

Home telephone

_____

☐ OK to leave message with detailed information

☐ Leave message with callback number only

Work telephone

_____

☐ OK to leave message with detailed information

☐ Leave message with callback number only

Written medical communication

☐ OK to mail to my home address

☐ OK to mail to my work / office address

☐ OK to fax to this number: _____

Other communication instructions

_____

Persons authorized to receive information

Name	Relationship	Phone number
Name	Relationship	Phone number
Name	Relationship	Phone number

Patient name (print) _____ Birthdate _____

Signature _____ Date _____

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). Individuals also have the right to request confidential communications of PHI by alternative means, such as sending correspondence to their office instead of their home.