



## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex:  Age: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State:  Zip: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State:  Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
 SSN: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
 Drivers License #: \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
 If the patient is a minor, who is legally responsible? \_\_\_\_\_

## DENTAL HEALTH HISTORY

What is the reason for your visit today? \_\_\_\_\_  
 Are you happy with your teeth and their appearance? \_\_\_\_\_ If not, what would you like to see different? \_\_\_\_\_  
 Have you ever bleached your teeth? \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_  
 Why did you leave your last dentist? \_\_\_\_\_

### Please check any boxes you would answer "yes" to:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Are you apprehensive about dental treatment?  | <input type="checkbox"/> Do you clench or grind your teeth frequently?  | <input type="checkbox"/> Are you aware of an uncomfortable bite?   |
| <input type="checkbox"/> Have you had problems with previous dental care?  | <input type="checkbox"/> Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? | <input type="checkbox"/> Have you had a blow to the jaw (trauma)?  |
| <input type="checkbox"/> Are you interested in nitrous oxide (laughing gas)?   | <input type="checkbox"/> Have you ever had a TMJ problem?   | <input type="checkbox"/> Are you interested in a non-surgical way to stop you or your spouse from snoring? |
| <input type="checkbox"/> Are you interested in oral sedation for longer appointments? This involves taking oral medication before and during your appointment to help you relax and forget most, if not all, of your dental appointment? | <input type="checkbox"/> Do you get frequent or severe headaches?   | <input type="checkbox"/> Are you tired, fatigued, or sleepy most days?                                     |
| <input type="checkbox"/> Do you have cold sores, aphthous ulcers (canker sores), or other sores in or about your mouth?  | <input type="checkbox"/> Are you interested in straightening crowded teeth or closing gaps between teeth?             | <input type="checkbox"/> Have you ever been told that you gasp for air or struggle to breathe at night?    |
|  | <input type="checkbox"/> Are your teeth sensitive to hot, cold or sweets? Please list: _____                          | <input type="checkbox"/> Have you ever bleached your teeth? If so, were you happy with the results? _____  |

How often do you brush? \_\_\_\_\_  
 Floss? \_\_\_\_\_

## FINANCIAL POLICY

A service charge of 1.5% per month (18% annual rate) will be applied to balances over 60 days, \$1.00 minimum charge. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the insurance claim. If the patient is a minor, permission is granted for dental treatment, as deemed necessary to be performed in our office or until written notice is given discounting this permission.

I hereby authorize payment of the dental benefits directly to Bruce DMD and Ririe DDS.

Signature required \_\_\_\_\_ Date \_\_\_\_\_

# MEDICAL HEALTH HISTORY

Please answer the following questions:

Physician name: \_\_\_\_\_ Date of last visit? \_\_\_\_\_ Condition treated: \_\_\_\_\_

Please list any medications you are taking, including prescription, over the counter, or herbal medications and/or supplements?

Are you in good health? If there were any changes in your general health within the past year please describe them.

Do you use tobacco (smoking, snuff, chew)? Frequency and amount: \_\_\_\_\_

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If so, when? \_\_\_\_\_

Are you required by your physician to take premedication before dental treatment? \_\_\_\_\_

Do you currently take any bisphosphate medications for osteoporosis or cancer treatment (Fosamax, Actonal, Zometa, Aredia, Boniva, etc)? \_\_\_\_\_ If yes, which medication? \_\_\_\_\_

**Do you have, or have you had, any of the following?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Cancer/Tumor<br>If yes, were you treated with any of the following:<br><input type="checkbox"/> Surgery<br><input type="checkbox"/> Radiation<br><input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Easy Bruising<br><input type="checkbox"/> Abnormal bleeding or blood disease<br><input type="checkbox"/> Allergy Problems<br><input type="checkbox"/> Seasonal Allergies<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Intestinal Problems<br><input type="checkbox"/> Ulcers<br><input type="checkbox"/> Weight gain or loss<br><input type="checkbox"/> Frequent heartburn/GERD<br><input type="checkbox"/> Kidney or bladder problems<br><input type="checkbox"/> Bone or Joint Problems<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Back or neck pain<br><input type="checkbox"/> Joint replacement | <input type="checkbox"/> Diabetes<br><input type="checkbox"/> Family history of diabetes<br><input type="checkbox"/> Thirsty or mouth is dry most of the time<br><input type="checkbox"/> Tuberculosis or other respiratory disease<br><input type="checkbox"/> Hepatitis, jaundice, or liver trouble<br><input type="checkbox"/> Sexually transmitted or blood born disease<br>If yes, which disease? _____<br><input type="checkbox"/> Fainting spells, seizures, or epilepsy<br><input type="checkbox"/> Stroke(s)<br><input type="checkbox"/> Epilepsy or other neurological disease<br><input type="checkbox"/> History of chemical dependancy<br><input type="checkbox"/> Persistent cough or swollen glands<br><input type="checkbox"/> Have you taken any diet drugs (Redux, Pondimin, or Phen-fen)<br><input type="checkbox"/> Thyroid problems |
|---|--|--|

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe.

**Are you allergic, or have you reacted adversely, to any of the following?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Local anesthetics (e.g. Novocaine)        | <input type="checkbox"/> Aspirin, Acetaminophen, or Ibuprofen | <input type="checkbox"/> Sulfa drugs        |
| <input type="checkbox"/> Penicillin or other antibiotics           | <input type="checkbox"/> Codeine, Demerol, or other narcotics | <input type="checkbox"/> Reaction to metals |
| <input type="checkbox"/> Barbituates, sedatives, or sleeping pills | <input type="checkbox"/> Latex or rubber dam                  | Other _____                                 |

**During the past 12 months, have you taken any of the following?**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Antibiotics or sulfa drugs         | <input type="checkbox"/> Digitalis or drugs for heart trouble | <input type="checkbox"/> Aspirin              |
| <input type="checkbox"/> Anticoagulants (e.g. Coumadin)     | <input type="checkbox"/> Tranquilizers                        | <input type="checkbox"/> Nitroglycerin        |
| <input type="checkbox"/> High blood pressure medicine       | <input type="checkbox"/> Nonprescription drugs/supplements    | <input type="checkbox"/> Cortisone (steroids) |
| <input type="checkbox"/> Insulin, Orinase, or similar drugs | <input type="checkbox"/> Natural remedies                     | Other _____                                   |

**Women - Please mark the box for each "yes" answer**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Are you taking contraceptives or hormones                      | <input type="checkbox"/> Are you nursing? | <input type="checkbox"/> Are you pregnant or do you think you might be pregnant? |
| <input type="checkbox"/> Have you reached menopause? If so, do you have symptoms? _____ |   |  |

I verify that the above information is correct to the best of my knowledge (Please Sign): \_\_\_\_\_