JOHN A. RIDD
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DENTISTRY
COSMETIC FAMILY IMPLANT

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WELCOME

Thank you for selecting our dental healthcare team. To help us provide you with the best possible dental care, please fill out this form completely. If you have any questions or need assistance, please ask us — we will be happy to help.

PATIENT INFORMATION (CONFIDENTIAL)

Today's Date: ____________________

Name____________________ Birthdate_____/_____/_____ Age ________ Sex ☐ M ☐ F
Last First Initial

Address____________________ Social Security # ________ - ________ - ________

City____________________ State__________ Zip __________

E-Mail____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer____________________ Occupation ____________________

Spouse's Name____________________ Birthdate__________ SS #__________

Spouse's Employer____________________ Spouse's Occupation____________________

If patient is a student, name of school/college__________ City__________ State__________

Whom may we thank for referring you? ____________________

PHONE NUMBERS

Home (_____) __________ Work (_____) __________ Ext.______ Cell Phone (_____) __________

Spouse's Work (_____) __________ Best time and place to reach you ____________________

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name____________________ Relationship ____________________

Home Phone (_____) __________ Work Phone (_____) __________

DENTAL INFORMATION

Reason for today's visit ____________________

____

____

Former Dentist ____________________

City/State____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

How often do you floss? ____________________

How often do you brush? ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or check biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name____________________ Date of last visit____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes	No
High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Angina	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No
Irregular Heartbeat/Pacemaker	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stroke/Circulatory Problems	☐ Yes	☐ No
Swollen Feet or Ankles	☐ Yes	☐ No
Respiratory Disease	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Cough, Persistent or Bloody	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Leukemia	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Bleeding Abnormality, with Extractions or Surgery	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No
Radiation Treatment	☐ Yes	☐ No
Tumor or Growth on Head or Neck	☐ Yes	☐ No
Sudden Weight Loss	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Fainting or Seizures	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Nervous Problems	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No
Joint Replacement or Implant	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Swollen Neck Glands	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Tonsillitis	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Herpes	☐ Yes	☐ No
AID/HIV Infection	☐ Yes	☐ No
Do you use marijuana, cocaine or other drugs?	☐ Yes	☐ No
Do you consume more than 2 alcoholic beverages/day?	☐ Yes	☐ No

Have you ever taken any of the group of drugs collectively referred to as bisphosphonates? These include Fosamax, Actonel, Boniva, Zometa, Aredia, Didronel and Reclast. ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No Due Date ____________ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

____

____

____

____

Pharmacy Name ____________________

ALLERGIES

☐ Aspirin
☐ Local Anesthetic
☐ Barbiturates (sleeping pills)
☐ Penicillin
☐ Codeine
☐ Sulfa
☐ Iodine
☐ Other ____________
☐ Latex
____

INSURANCE INFORMATION

Name of insured____________________ Relationship to patient____________________

Birthdate____________________ Social Security # ____________________

Insurance Company____________________ Group # ____________________

____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medications as indicated.

X____________________ Date____________________

(Signature of patient or parent of minor)

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