RITCHIE DENTAL GROUP, PA
PATIENT INFORMATION & HEALTH UPDATE

PATIENT INFORMATION

Patient Name:		Sex: M / F	Select One of the Following: Single Married Separated Widowed
DOB:	Age:		SSN:
Mailing Address:	City:	State:	Zip Code:
Email:	Home #:		Cell #:
Employer Name & Address:			Work #:
Occupation:	Name of Spouse:		Spouse's Cell #:

DENTAL INSURANCE INFORMATION

Insurance Name:	Member ID #:	Group #:
Policy Holder's Information: Name:	DOB:	SSN:
Name & Address of Policy Holder's Employer:		

EMERGENCY CONTACT INFORMATION

Emergency Contact:	Address:
Phone #:	Relationship to Patient:

DENTAL HISTORY

Please check any of the following that apply to you:

- ☐ Sensitivity (Hot, Cold, Sweet)
  Where?
  UR UL LR LL
- ☐ Headaches, Ear Aches, or Neck Pain
- ☐ Jaw Joint Pain
- ☐ Mouth Ulcers/Cold Sores
- ☐ Broken Teeth or Fillings
- ☐ Grinding or Clenching Teeth
- ☐ Bleeding, Swollen, Irritated Gums
- ☐ Loose, Tipped, or Shifting Teeth
- ☐ Bad Breath

Do you have OR have you had any of the following?

- ☐ Dentures
- ☐ Partial Dentures
- ☐ Braces
- ☐ Gum Treatments

If you could whiten your teeth for a cost anyone could afford, would you do it?

Yes No

Do you smoke or use chewing tobacco?

Yes No

If Yes:

How long? ____________________

How much? ____________________

If I could change my smile, I would:

- ☐ make my teeth whiter
- ☐ make my teeth straighter
- ☐ close spaces
- ☐ replace metal fillings with tooth colored fillings
- ☐ repair chipped teeth
- ☐ replace missing teeth
- ☐ replace crowns that don't match
- ☐ have a smile makeover

What is most important, to you, about your future smile & dental health?

____

What is most important, to you, about your dental visit today?

____

On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Are you currently under a physician's care? ☐Yes ☐No For what? ____________________

Physician: ____________________ Phone#: ____________________

Please check any of the following that apply to you:

☐Anemia	☐Depression	☐High Blood Pressure	☐Rheumatoid Arthritis
☐Anxiety	☐Diabetes	☐High Cholesterol	☐Ringing/Buzzing of Ears
☐Aortic Stenosis	☐Difficulty Swallowing	☐HIV/AIDS	☐Shingles
☐Artificial Joints	☐Endocarditis	☐Kidney Disease	☐Sleep Apnea
☐Artificial Valves	☐Epilepsy/Seizures	☐Liver Disease	☐Snoring
☐Asthma	☐Fainting/Dizziness	☐Mitral Valve Prolapse	☐Stomach Ulcer/ U.C.
☐Back Problems	☐Glaucoma	☐Migraines	☐Stroke
☐Blood Disease	☐Headaches	☐Osteoporosis	☐Surgical Implant
☐Blood Thinners	☐Heart Disease	☐Osteopenia	☐Tachycardia
☐Cancer	☐Hemophelia	☐Pacemaker	☐Thyroid Disease
☐Chemotherapy	☐Hepatitis	☐Radiation Treatment	☐Tobacco Habit
☐Circulatory Problems	☐Herpes/Cold Sores	☐Respiratory Problems	☐Tuberculosis

Are you allergic to any of the following?

☐Aspirin	☐Erythromycin	☐Penicillin
☐Codeine	☐Latex	☐Sulfa
☐Epinephrine	☐Nitrous Oxide	☐Other ____________

For Women Only:

- ☐Birth Control
- ☐Breast Feeding
- ☐Pregnant ...How far along? ____________

Please list any major surgeries you have had:

____________________ Year: ________

____________________ Year: ________

____________________ Year: ________

____________________ Year: ________

What medications are you currently taking?

____

____

____

____