John A. Ritchie D.D.S.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. All information provided is confidential.

PATIENT INFORMATION

Name		Soc. Sec. #		
Address			Email	
City	State	Zip	Home Phone	Cell Phone
Sex □ M □ F	Birthdate	□ Single □ Married	Spouse's 1st name	
Occupation	Employer		Work Phone	Ext
Emergency contact name		Relation to you		
Address	Cell Phone		Work Phone	Ext
How did you discover our practice?	□ Street Sign	□ Christian Blue Pages	□ Yellow Pages	□ Internet/Web site
	□ Referred by:			
	□ I am a Previous Patient of Dr Ritchie		□ Other:	

PRIMARY INSURANCE

Are you covered by Dental Insurance? □Y □ N		Subscriber's Name	
Relation to you	Soc Sec #		Insured's Birthdate
Address *(if different from yours)*			
City	State	Zip	Home Phone
Cell Phone	Email		
Employed by		Occupation	
Business Address			Work Phone Ext
Insurance Company		Phone	
Contract #	Group #	Subscriber #	
Name of other dependents under this plan			

ADDITIONAL INSURANCE

Are you covered by additional Insurance? □Yes □ No

Subscriber Name

Relation to you	Soc Sec #		Insured's Birthdate
Address *(if different from yours)*			
City	State	Zip	Home Phone
Cell Phone	Email		
Employed by			Work Phone Ext
Insurance Company		Phone	
Contract #	Group #	Subscriber #	
Name of other dependents under this plan			

Please complete both sides ☺

DENTAL HISTORY

How can we help you today?

Former Dentist | Address | Phone

Date of last dental visit | Date of last x-rays

What type of dental care did you receive during your last visit to the dentist?

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □Y □ N If yes, describe

Are you experiencing any dental pain or discomfort? □Y □ N

Have you ever experienced a mouth injury? □Y □ N

How many sodas do you consume (on average) per week?_____

Habits affecting the mouth or teeth: □ Tooth clenching or night time grinding □ Smoking □ Use smokeless tobacco products □ Excessive gum chewing

Do you have any specific dental problems or need for treatment that Dr Ritchie should know about? □Y □ N If yes, describe

MEDICAL HISTORY

Physician's Name | Date of last medical checkup

Address | Phone

Have you had any serious illnesses or operations? □Y □ N If yes, describe

Are you currently under physician's care? □ Y □ N If yes, describe

Do you or have you taken bisphosphanate medications intravenously or orally (Ex: **Aredia, Zometa, Fosamax, Actonel, Boniva**) □ Y □ N

Does your physician require that you take antibiotics before dental procedures? □ Y □ N If yes, which one?

Check (√) yes or no if you currently have or have had any of the following diseases or conditions:

□ Y □ N Cough up blood	□ Y □ N Hemophilia/ Abnormal bleeding	□ Y □ N Shortness of breath	□ Y □ N Anemia
□ Y □ N Hepatitis/Jaundice		□ Y □ N Sinus problems	□ Y □ N Prolonged healing
□ Y □ N Diabetes	□ Y □ N Asthma	□ Y □ N AIDS/HIV Positive	□ Y □ N Stroke
□ Y □ N Skin Rash	□ Y □ N Rheumatic fever	□ Y □ N Seasonal allergies	□ Y □ N Fainting spells
□ Y □ N Headaches	□ Y □ N Tuberculosis	□ Y □ N Food allergies	□ Y □ N Material allergies
□ Y □ N Kidney disease	□ Y □ N Liver disease	□ Y □ N Thyroid disease	(latex, wool, metal, chemicals)
□ Y □ N Venereal disease	□ Y □ N Hearing Impairment	□ Y □ N Organ transplant	□ Y □ N Seizures/Epilepsy
□ Y □ N Heart Murmur	□ Y □ N Mitral valve prolapse	□ Y □ N Persistent cough	□ Y □ N Cold sores/Herpes
□ Y □ N Low blood pressure	□ Y □ N High blood pressure	□ Y □ N Heart attack	□ Y □ N Hip/knee replacement
□ Y □ N Pain in chest	□ Y □ N Swollen ankles	□ Y □ N Radiation treatment	□ Y □ N Pregnant (women only)
□ Y □ N Respiratory disease	□ Y □ N Blood disease	□ Y □ N Cancer	□ Y □ N Heart disease
Describe:_____	Describe:_____	Describe:_____	Describe:_____

Do you have any disease, condition or problem not listed above that Dr Ritchie should know about? □ Y □ N If yes, describe

List medications you are taking:

Are you sensitive or allergic to any of the following:

Penicillin □ Y □ N Novocaine □ Y □ N Codeine □ Y □ N

Aspirin □ Y □ N Other antibiotic/drug □ Y □ N_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr Ritchie to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr Ritchie.
My signature on this form also authorizes the following:

- The insurance company indicated on this form to pay to Dr Ritchie all insurance benefits otherwise payable to me for services rendered and the use of this signature on all insurance submissions.
- Dr Ritchie to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether paid by insurance or not.

Signature: Date:

Patient's portion of payment is due in full at time of treatment, unless prior arrangements have been approved.