WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Patient's Name _____ Soc. Sec. #_____
Last Name First Name Initial

Patient's Birthdate:_____ Sex: M____ F____ Email:_____Cell#_____ _____

Home Phone #_____ Residence Address _____

City _____ State _____ Zip_____

Patient Employed By:_____ Business Phone # _____

Spouse's Name _____ SS #_____ Birthdate___/___/___
Last Name First Name Initial

Spouse Employed By _____Business Phone #_____

In case of emergency who should be notified? _____
Name Address Phone #

Referred by (Who may we thank for referring you?_____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Primary Dental Insurance Coverage _____

Secondary Dental Insurance Coverage _____

Best Time To Be Reached At Home _____

Preferred Appointment Times _____

Authorization

- I authorize the dentist to perform an examination, diagnostic procedures and prophylaxis as may be necessary for proper dental evaluation.
- **I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.**
- **I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.**
- **I authorize the use of this signature on all insurance submissions.**
- **I authorize the dentist to release all information necessary to secure the payment of benefits.**
- **I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature _____ Date_____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Minor

IF YOU ARE UNDER THE AGE OF EIGHTEEN YEARS

Name of Father_____ SS #_____ Birthdate___/___/___

Father Employed By_____Business Phone #_____

Name of Mother _____ SS #_____ Birthdate___/___/___

Mother Employed By _____Business Phone #_____

The benefits of a healthy, beautiful smile are immeasurable and our goal will be to enable you to obtain the strong teeth and attractive smile that you deserve. ~ Dr. Cornal Ridgell

It is important to tell all dental personnel involved in your treatment about the general state of your health.
This information is confidential.

Name _____ Date of Birth _____

1. Former Dentist _____ Address _____
2. When did you last visit a dentist? _____ X-rays taken? Yes ____ No ____
   What was done at that time? _____
   Why did you leave that practice? _____
3. Have you lost or have had any teeth removed, including wisdom teeth? Yes ____ No ____
   Why? _____
4. Do you have any bridge work or dentures? _____
5. Are you unhappy with the replacement? Yes ____ No ____ Why _____
6. Do you feel your breath is offensive at times? Yes ____ No ____
7. Have you ever been told you have gum disease? Yes ____ No ____
8. Have you ever had gum treatment or Surgery? Yes ____ No ____
9. Does food chronically collect between your teeth? Yes ____ No ____
10. Are your teeth acutely sensitive to: Sweet ❑ Cold ❑ Heat ❑ Pressure ❑ No ❑
11. How often do you brush your teeth? _____
12. How often do you floss your teeth? _____
13. Do you clench or grind your teeth? Yes ____ No ____
14. Does your jaw click or pop? Yes ____ No ____
15. Do you have frequent headaches? Yes ____ No ____
16. Have you had any orthodontic work? Yes ____ No ____
17. Has any dental treatment been recommended to you that you have not had done? _____
    _____
18. Are you happy with the appearance of your smile? Yes ____ No ____ Explain _____
    _____
19. Anything else that would be valuable for me to know? Yes ____ No ____ Explain _____
    _____

I certify that the above information is complete and accurate.

Patient's/Guardian's Signature _____ Date _____

DENTAL HISTORY REPORT

MEDICAL HISTORY

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is confidential.

Patients Name: _____ **DATE OF BIRTH**_____

Patients Home/Cell Phone Number: _____

1. Name and address of physician _____
2. When was your last physical examination?_____
3. Are you now under the care of a physician? Yes ☐ No ☐ If yes, for what reason?_____
   _____
   _____
4. Have you been told you should be taking an antibiotic (premedication) prior to dental visits?.....Yes ☐ No ☐
5. Are you taking a blood thinner (Coumadin)? .....Yes ☐ No ☐
6. Are you presently taking any medications/drugs/pills? .....Yes ☐ No ☐
   Please List: _____
   _____
   _____
7. Are you presently taking a medication for soft bone (osteoporosis) (Fosamax)? Yes ☐ No ☐
8. (Women) Are you pregnant? Yes ☐ No ☐ If yes, how long?_____
9. Are you allergic to: Penicillin ☐ Codeine ☐ Local Anesthetic ☐ Latex ☐ None ☐ Other ☐_____
   Pharmacy Name:_____ Pharmacy Phone Number:_____
10. Do you have, or have you ever had:

Heart Trouble	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐
Heart Murmur	Yes ☐ No ☐	Excessive or Prolonged Bleeding	Yes ☐ No ☐
Heart Surgery	Yes ☐ No ☐	Fainting Spells	Yes ☐ No ☐
Heart Pacemaker	Yes ☐ No ☐	Jaundice	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Hepatitis - Type:	Yes ☐ No ☐
High or Low Blood Pressure	Yes ☐ No ☐	Asthma or Hay Fever	Yes ☐ No ☐
Ulcers	Yes ☐ No ☐	Sinus Trouble	Yes ☐ No ☐
Tuberculosis or Lung Disease	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Chemotherapy/Radiation	Yes ☐ No ☐
Epilepsy or Seizure Disorders	Yes ☐ No ☐	Stroke	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Glaucoma	Yes ☐ No ☐
Thyroid Problem	Yes ☐ No ☐	Psychiatric Care	Yes ☐ No ☐
Chemical Dependency	Yes ☐ No ☐	Venereal Disease	Yes ☐ No ☐
Smoke/Chew or use any form Tobacco	Yes ☐ No ☐	HIV Positive/AIDS/ARC	Yes ☐ No ☐
		Prosthetic Implant/Joint Replacement	Yes ☐ No ☐

11. Have you had any other serious illnesses, hospitalization or accident? Yes ☐ No ☐
    If yes, please explain _____
    _____
    _____

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

OFFICE USE ONLY

DATE _____

1. Any changes in medical history?	Y or N
2. Are you under a doctor's care?	Y or N
3. Any changes in medications or dosages?	Y or N
4. Any new allergies?	Y or N
5. Are you pregnant or nursing?	Y or N

Notes:_____

Signature:_____

DATE _____

1. Any changes in medical history?	Y or N
2. Are you under a doctor's care?	Y or N
3. Any changes in medications or dosages?	Y or N
4. Any new allergies?	Y or N
5. Are you pregnant or nursing?	Y or N

Notes:_____

Signature:_____