Harry Ringer D.D.S.
Family & Cosmetic Dentistry

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Patient Information Sheet

_____ Date of Birth _____

Last Name _____ First Name _____ Middle Name _____

Address _____ City _____ State _____ Zip _____

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

Employer _____ Address _____ City _____

Driver's License _____ Social Security # _____

Spouse's Name _____

Address _____ City _____ State _____ Zip _____

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

Employer _____ Address _____ City _____

Emergency Contact _____ Phone (_____) _____

If patient is a minor, who is legally responsible? _____

Date of last dental treatment _____ Where? _____

Date of last X-Rays _____ Referred by _____

Family Physician _____ Address _____

Dental Insurance Information

Insured Member _____ Relationship to Patient _____

Address _____

Employer of Insured Member _____ Phone (_____) _____

Insurance Plan _____ Group # _____ SS# _____

Is there dual coverage?_____ Subscriber Name _____

What Insurance Company? _____

Are you a full time student?_____ Where? _____

I hereby grant authority to: HARRY RINGER, D.D.S. and/or to the dentist(s) in charge of my care, to administer any treatment, to administer such anesthetics; and to perform such operations as may be deemed necessary in the diagnosis and treatment of my case. I authorize the taking of radiographs, photographs, or other diagnostic aids as needed for a thorough evaluation.

I acknowledge that I have been informed of the risks and possible consequences of the operation/s proposed and do authorize the above named doctor(s) to proceed, and will assume financial responsibility.

Signed _____ Date _____

Patient or legal guardian in the case when the patient is a minor or physically or mentally incompetent.

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Medical History

1. Are you having pain or discomfort at this time? . . . . . Yes . . . . . No
2. Do you feel very nervous about having dental treatment? . . . . . Yes . . . . . No
3. Have you ever had a bad experience in a dental office? . . . . . Yes . . . . . No
4. Have you been a patient in a hospital during the past two years? . . . . . Yes . . . . . No
5. Have you been under the care of a medical doctor during the past two years? . . . . . Yes . . . . . No
6. Have you taken any medicine or drugs during the past two years?. . . . . Yes . . . . . No
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, local anesthetic or any drugs or medications? . . . . . Yes . . . . . No
8. Have you ever had any excessive bleeding requiring special treatment? . . . . . Yes . . . . . No
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema AIDS/HIV Infection	Bruise Easily
Heart Disease or Attack	Cough Hepatitis A (infectious)	Sickle Cell Disease
Angina Pectoris	Tuberculosis (TB) Hepatitis B (serum)	Pain in Jaw Joints
High Blood Pressure	Asthma Liver Disease	Ulcers
Heart Murmur	Hay Fever Yellow Jaundice	Psychiatric Treatment
Rheumatic Fever	Sinus Trouble Blood Transfusion	Glaucoma
Congenital Heart Lesions	Allergies or Hives Drug Addiction	Kidney Trouble
Scarlet Fever	Hemophilia Artificial Heart Valve	Diabetes
Heart Pacemaker	X-ray or Cobalt Treatment Cold Sores	Thyroid Disease
Heart Surgery	Chemotherapy (Cancer, Leukemia) Genital Herpes	Stroke
Artificial Joint	Arthritis Epilepsy or Seizures	Head or Neck Trauma
Anemia	Rheumatism Fainting or Dizzy Spells	
Cortisone Medicine	Nervousness	
Venereal Disease (Syphilis, Gonorrhea)		

10. Do you experience pain in your chest, shortness of breath, or tire easily during mild exertion?. . . . Yes . . . . . No
12. Have you lost or gained more than ten pounds n the past year? . . . . . Yes . . . . . No
13. Do you ever wake up from sleep short of breath?. . . . . Yes . . . . . No
14. Are you on a special diet? . . . . . Yes . . . . . No
15. Has your medical doctor ever said you have a cancer or tumor? . . . . . Yes . . . . . No
16. Do you have any disease, condition, or problem not listed? . . . . . Yes . . . . . No
17. Have you ever been advised to take prophylactic antibiolics prior to dental treatment? . . . . . Yes . . . . . No
18. WOMEN: Are you pregnant now? . . . . . Yes . . . . . No
    Do you anticipate becoming pregnant?. . . . . Yes . . . . . No
    Are you practicing birth control? . . . . . Yes . . . . . No

NOTE: tf prescribed antibiotics, there is the potential that your birth control's function may be effected.

To the best of my know/edge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Signed _____ Date _____
Patient, Parent or Guardian

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Medications

Date	Medication	Purpose	Frequency

Note any changes since last dental appointment.

Date	Medication	Purpose	Frequency

Date	Medication	Purpose	Frequency

Date	Medication	Purpose	Frequency

Date	Medication	Purpose	Frequency

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Personalized Esthetic Evaluation

Patient Name_____ Date _____

Please answer the following questions that are specifically designed to aid our diagnosis and treatment of your esthetic needs:

1. Do you dislike the color of your teeth? . . . . . Yes . . . . No
2. Do you have spaces between your teeth? . . . . . Yes . . . . No
3. Do you have chips or uneven edges on your teeth? . . . . . Yes . . . . No
4. Do you have any dark fillings visible? . . . . . Yes . . . . No
5. Are your teeth too short?. . . . . Yes . . . . No
6. Are your teeth too long? . . . . . Yes . . . . No
7. Are your teeth too crowded? . . . . . Yes . . . . No
8. Do your teeth feel “notched” at the gum line? . . . . . Yes . . . . No
9. Do your gums show when you are smiling? . . . . . Yes . . . . No
10. Do your gums feel unhealthy? . . . . . Yes . . . . No
11. Do your gums feel irregular in contour? . . . . . Yes . . . . No
12. Have you ever had orthodontic treatment? . . . . . Yes . . . . No
13. Are you satisfied with your facial appearance? . . . . . Yes . . . . No

    If not, why? _____

    _____

14. If your smile were improved, would you feel more satisfied? . . . . Yes . . . . No

15. In general, how would you improve your smile?. . . . . .

_____

_____

Evaluator Comments: _____

_____

_____

_____

_____

_____

Evaluator’s Signature _____