



**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 in 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 antibiotics 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: If 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 \_\_\_\_\_