Robert N. Ryan, DDS

Chico Creek DENTAL

Patient Information

Patient Name ______________________ Date ______________
Age _____ Birthdate ______________ SS# __________________Gender __M __F Marital Status __S __M __W __D
Driver's Lic# ______________ Email Address ____________________ Ok to contact via E-Mail? __Y __N
Address ______________________ City ______________ State______ Zip ______________
Phone: Home ______________ Work ______________Cell ______________ Best # to call ______________
Employer ______________________ Phone ______________________
Address ____
Emergency Contact Name ______________________ Phone ______________

Referral Information

Whom may we thank for referring you to our office? ______________________

Spouse or Responsible Party

Name ______________________Relationship to patient ______________
Birthdate ______________ SS# ______________ Driver's Lic# ______________
Address ______________________ City ______________State ______ Zip ______________
Phone: Home ______________Work ______________ Cell ______________ Best # to call ______________
Employer ______________________ Phone ______________________
Address ____
May we discuss your treatment with the above person? __Y __N

Insurance Information

Insured ______________________ Birthdate ______________ SS# ______________
Insurance Co ______________________________Group # ______________
Other Coverage ____

Are Your Teeth Sensitive To...

	YES	NO
1. Heat?	___	___
2. Cold?	___	___
3. Sweets?	___	___
4. Biting Pressure?	___	___
5. Do your gums bleed when brushing?	___	___
6. Do you ever avoid any part of your mouth when brushing?	___	___
7. Are you dissatisfied with your teeth and their appearance?	___	___
8. Do you want your teeth to be whiter?	___	___
9. Are you concerned about the finances required to return your mouth to excellent dental health?	___	___
10. Do you become frustrated because you always have something to be treated or repaired when you visit the dentist?	___	___
11. Have you ever had any teeth removed?	___	___
12. Do you feel you will eventually wear dentures?	___	___

Current Care

Who is your primary care physician? ______________________
How would you describe the condition of your teeth? __Excellent __Good __Fair __Poor

Anxiety Questionnaire

How would you rate your level of fear or anxiety?
__NONE __LOW __MODERATE __SEVERE

Is your Anxiety related to:
__PAIN __NEEDLES __NOISE __OTHER

Have you ever been told...

__That you snore? __That you stop breathing at night? __That you have an irregular heartbeat? (A-FIB)
Reason for today's appointment? ______________________

HEALTH HISTORY

Check appropriate answer (leave blank if you do not understand question):

1. Is your general health good? .... ____YES ____NO
2. Has there been a change in your health within the last year? .... ____ YES ____NO
3. Have you been hospitalized or had a serious illness in the last three years? .... ____ YES ____NO
   Why/describe? ______________________________
4. Are you being treated by a physician now? .... ____YES ____ NO
   For What? ______________________________
   Date of your last medical exam ____________ Date of last Dental Appt.: ____________
5. Have you ever had problems with prior dental treatment? .... ____ YES ____NO
6. Are you in pain now? .... ____ YES ____ NO

HAVE YOU EXPERIENCED:

7. Chest pain (angina)? .... ____YES ____ NO
8. Swollen ankles? .... ____YES ____ NO
9. Shortness of breath? .... ____YES ____ NO
10. Weight loss, fever, night sweats? .... ____YES ____ NO
11. Persistent cough, coughing up blood? ... ____YES ____ NO
12. Bleeding problems, bruising easily? .... ____YES ____ NO
13. Sinus problems? .... ____YES ____ NO
14. Difficulty swallowing? .... ____YES ____ NO
15. Diarrhea, constipation, blood in stools? .. ____YES ____ NO
16. Frequent vomiting, nausea? .... ____YES ____ NO
17. Difficulty urinating, blood in urine? .... ____YES ____ NO
18. Dizziness? .... ____YES ____NO
19. Ringing in the ears? .... ____YES ____NO
20. Headaches? .... ____YES ____NO
21. Fainting Spells? .... ____YES ____NO
22. Blurred Vision? .... ____YES ____NO
23. Seizures? .... ____YES ____NO
24. Excessive thirst? .... ____YES ____NO
25. Frequent urination? .... ____YES ____NO
26. Dry mouth? .... ____YES ____NO
27. Jaundice? .... ____YES ____NO
28. Joint pain, stiffness? ... ____YES ____NO

DO YOU HAVE OR HAVE YOU HAD:

29. Heart Disease? .... ____ YES ____NO
30. Heart attack, heart defects? .... ____ YES ____NO
31. Heart murmurs? .... ____ YES ____NO
32. Rheumatic fever? .... ____ YES ____NO
33. Stroke, hardening of arteries? .... ____ YES ____NO
34. High blood pressure? .... ____ YES ____NO
35. TB, emphysema, other lung diseases? .... ____ YES ____NO
36. Hepatitis, other liver disease? .... ____ YES ____NO
37. Stomach problems, ulcers? .... ____ YES ____NO
38. Allergies to: drugs, foods, medications? . ____ YES ____NO
39. Family history of diabetes, heart problems, tumors? ____ YES ____NO
40. AIDS or ARC? .... ____YES ____NO
41. Tumors, cancer? .... ____YES ____NO
42. Arthritis, rheumatism?. ____YES ____NO
43. Eye disease? .... ____YES ____NO
44. Skin disease? .... ____YES ____NO
45. Anemia? .... ____YES ____NO
46. Herpes? .... ____YES ____NO
47. Kidney, bladder disease? ____YES ____NO
48. Thyroid, adrenal disease? ____YES ____NO
49. Diabetes? .... ____YES ____NO

DO YOU HAVE OR HAVE YOU HAD:

50. Psychiatric care? .... ____ YES ____NO
51. Radiation Treatments? .... ____ YES ____NO
52. Chemotherapy .... ____ YES ____NO
53. Prosthetic heart valve? .... ____ YES ____NO
54. Artificial joint? .... ____ YES ____NO
55. Hospitalization? .... ____YES ____NO
56. Blood transfusions? ..... ____YES ____NO
57. Surgeries? .... ____YES ____NO
58. Pacemaker? .... ____YES ____NO
59. Contact lenses? .... ____YES ____NO

ARE YOU TAKING:

60. Recreational drugs? .... ____ YES ____NO
61. Drugs, medications, (include: Aspirin)? .. ____ YES ____NO
    Please list: ______________________________
62. Tobacco in any form? ____YES ____NO
63. Alcohol? .... ____YES ____NO

WOMEN ONLY:

64. Are you or could you be pregnant or nursing? ___ YES ___ NO
65. Taking birth control pills? ____YES ____NO

ALL PATIENTS:

66. Do you have or have you had any other diseases or medical problems NOT listed on this form? __ YES __NO
    If so, please explain: ______________________________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient Signature ______________________ Date ____________

RECALL REVIEW:

1. Patient Signature ______________________ Date ____________
2. Patient Signature ______________________ Date ____________
3. Patient Signature ______________________ Date ____________