Welcome! We are pleased to welcome you to the practice of Dr. Stephen W. Ritz, D.D.S.
We look forward to working with you in maintaining your dental health.

Patient Information

Last Name_____ First Name_____ Middle Initial_____

Preferred Name_____ Birthdate_____ Social Security Number_____

Address_____City_____State_____Zip Code_____

Home Phone_____ Cell Phone _____

Head of the Account _____ Address _____

Sex: __ Male__ Female ____ Single ____ Married ____Widowed ____Divorced

Patient Employed By _____ Occupation _____

Whom should we notify in case of an emergency? _____ Relationship _____ Phone _____

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

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Dental Information

	Yes	No
Do your gums bleed when you brush?	□	□
Have you ever had orthodontic (braces) treatment?	□	□
Are your teeth sensitive to cold, hot, sweets or pressure?	□	□
Have you ever had any periodontal (gum) treatments?	□	□
Do you wear removable dental appliances?	□	□
Have you had a serious/difficult problem associated with any dental treatment?	□	□

How would you describe your current dental problem?
_____
Date of your last dental exam _____
Date of your last dental x-rays _____
What was done at that time? _____
How do you feel about the appearance of your teeth?
_____
How often do you brush your teeth? _____

Medical Information

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription medicine?	□	□
Have you had any serious illness, operation, or been hospitalized in the past 5 years?	□	□
Do you use drugs or other substances for recreational purposes?	□	□
Do you use tobacco (smoking, snuff, chew)?	□	□
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	□	□
Have you ever had intravenous bisphosphonates for skeletal problems or cancer?	□	□

If yes, what medicine(s) are you taking?
Prescribed: _____
_____
Over the counter: _____
_____
Vitamins, natural or herbal preparations and/or diet supplements:
_____

If yes, please list _____
If yes, how interested are you in stopping?
(circle one) Very/ Somewhat/ Not interested

If yes, what was the illness or problem? _____
_____
_____

Physicians Name _____
Physicians Address _____
Physicians Phone Number _____

Medical Information Continued

	Yes	No	Don't Know
Are you allergic to or have you had a reaction to?			
Local anesthetics	□	□	□
Aspirin	□	□	□
Penicillin or other antibiotics	□	□	□
Barbiturates, sedatives, or sleeping pills?	□	□	□
Sulfa drugs	□	□	□
Codeine or other narcotics	□	□	□
Latex	□	□	□
Iodine	□	□	□

To yes responses, specify type of reaction.

_____

_____

Women Only

Are you or could you be pregnant?	□	□	□
Nursing?	□	□	□
Taking birth control or hormonal replacement?	□	□	□

	Yes	No	Don't Know
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	□	□	□

If yes, when was this operation done? _____

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

_____

Has a physician recommended that you take antibiotic prior to your dental treatment?	□	□	□

Name of physician _____

Physician Phone Number _____

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
Abnormal bleeding	□	□	□
AIDS or HIV infection	□	□	□
Anemia	□	□	□
Arthritis	□	□	□
Rheumatoid arthritis	□	□	□
Asthma	□	□	□
Cancer/Chemotherapy/Radiation Treatment	□	□	□
Cardiovascular disease	□	□	□

If yes, describe _____

Disease, drug or radiation-induced immunosurpression	□	□	□
Diabetes. If yes, specify below:	□	□	□

_____Type I (Insulin dependent) _____Type II

Epilepsy	□	□	□
Fainting spells or seizures	□	□	□
Gastrointestinal disease	□	□	□
High Blood Pressure	□	□	□

	Yes	No	Don't Know
Hemophilia	□	□	□
Hepatitis, jaundice or liver disease	□	□	□
Kidney problems	□	□	□
Mental health disorders. If yes, specify:	□	□	□

_____

Neurological disorders. If yes, specify:	□	□	□

_____

Osteoporosis	□	□	□
Respiratory disorders. If yes, specify	□	□	□

_____

Sexually transmitted disease	□	□	□
Sinus trouble	□	□	□
Sleep disorder	□	□	□
Sores or ulcers in the mouth	□	□	□
Stroke	□	□	□
Tuberculosis	□	□	□
Thyroid problems	□	□	□

Do you have any disease, condition, or problem not listed above that you think I should know about?	□	□	□

Please explain: _____

_____

Note: Both Doctor and patient are encouraged to discuss and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I acknowledge financial responsibility for charges incurred and allow my insurance, if any, to pay Dr. Ritz directly.

_____ _____

Signature of patient/legal guardian Date