sm:)e Tracy Ruegsegger, DDS, PC

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient # _____

Patient _____

Address _____

City _____

State _____ Zip _____

E-Mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account> _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all

insurance benefits, if any, otherwise payable t me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext._____ Cell Phone(_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

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

HEALTH HISTORY

Please CIRCLE the appropriate response next to each question below: Yes (Y), No (N)

MEDICAL HISTORY

Do you have or have you had any of the following:

Breathing problems?

a. Asthma	Y	N
b. Emphysema	Y	N
c. Bronchitis	Y	N
d. Tuberculosis	Y	N
e. Shortness of breath	Y	N
f. Other breathing problems	Y	N

Explain: _____

Heart or circulation problems?

a. High blood pressure	Y	N
b. Heart attack	Y	N
c. Angina or chest pain	Y	N
d. Irregular heart beat	Y	N
e. Rheumatic fever	Y	N
f. Heart murmur	Y	N
g. Mitral valve prolapse	Y	N
h. Damage to heart valves	Y	N
i. Heart valve replacement	Y	N
j Pacemaker/other cardiac device	Y	N
k Congestive heart failure	Y	N
l. Swollen ankles	Y	N
m. Other heart or circulation problems	Y	N

Explain: _____

Kidney or urinary problems?

a. Kidney disease	Y	N
b. Dialysis	Y	N
c. Frequent urination	Y	N
d. Other kidney problems	Y	N

Explain: _____

Nervous system problems?

a. Stroke	Y	N
b. Fainting spells	Y	N
c. Convulsions, seizures or epilepsy	Y	N
d. Dementia	Y	N
e. Alzheimer's Disease	Y	N
f. Other nervous system problems	Y	N

Explain: _____

Head and neck problems?

a. Nose or sinus problems	Y	N
b. Swollen glands	Y	N
c. Oral cancer	Y	N
d. Impairment of hearing sight or speech	Y	N
e. Frequent or severe headaches	Y	N
f. Other head and neck problems	Y	N

Explain: _____

Hormone or gland problems?

a. Thyroid disease (hypothyroidism, hyperthyroidism)	Y	N
b. Diabetes	Y	N
c. Adrenal or pancreatic disease	Y	N
d. Any other hormone/gland disease	Y	N

Explain: _____

Muscle, bone or skin problems?

a. Arthritis	Y	N
b. Osteoporosis	Y	N
c. Artificial joint placement	Y	N
d. Hives or skin rash	Y	N
e. Skin cancer	Y	N
f. Back problems	Y	N
g. Other muscle, bone or skin disease	Y	N

Explain: _____

Stomach, liver or intestinal problems?

a. Liver disease	Y	N
b. Hepatitis	Y	N
c. Acid reflux (GERD)	Y	N
d. Ulcers	Y	N
e. Cirrhosis	Y	N
f. Other stomach, intestinal or liver problems	Y	N

Explain: _____

Other

a. Any other medical conditions that we have not listed?	Y	N
b. Have you ever needed a pre-medication prior to a dental appointment?	Y	N

DOCTOR'S COMMENTS _____

_____

_____

_____

next page please

MEDICAL HISTORY Continued

Allergic reactions or other problems?

a. Seasonal allergies	Y	N
b. Allergy, reaction or intolerance to:		
Penicillin	Y	N
Erythromycin	Y	N
Codeine	Y	N
Latex	Y	N
Local anesthetics	Y	N
Foods/flavoring	Y	N
Other substances	Y	N

Explain: _____

_____

_____

Blood or immune system problems?

a. Cancer of any type	Y	N
b. Organ or bone marrow transplant	Y	N
c. Lupus	Y	N
d. Multiple sclerosis	Y	N
e. Anemia	Y	N
f. Hemophilia	Y	N
g. AIDS/HIV	Y	N
h. Frequent nosebleeds, increased bruising or bleeding	Y	N
i. Are you taking any blood thinners?	Y	N
j. Have you had chemotherapy or radiation treatment?	Y	N
k. Other problems with the blood or immune system?	Y	N

Explain: _____

What medications or other substances are you taking or have you taken in the past 2 months?

a. Please list all prescription and non-prescription drugs including aspirin, birth control pills, herbal medications or other supplements. Write "none" if you are not taking any medications or other substances.

_____

_____

_____

_____

b. Have ever taken the drugs Fenfluramine (Fen-phen), Pondimin, or Dexfenfluramine (Redux)? Y N

c. Have you taken or are you taking drugs to control bone loss? (i.e. Fosamax®, Boniva®, Actonel®, Zometa®, Aredia®) Y N

Personal History

a. Have you ever been hospitalized, had major surgery or been seriously hurt? Y N

If yes, what type and when? _____

b. Have you had or do you have any sexually transmitted diseases (syphilis, gonorrhea, herpes, etc.) Y N

c. Do you need any special accommodations for dental treatment? Y N

d. Are you pregnant? Y N

e Have you ever used tobacco products? Y N

f. Are you currently using tobacco products? Y N

What type and how often? _____

g. How many alcohol containing drinks do you consume a week? _____

h. Do you use or have you used recreational drugs? Y N

i. Have you ever had a problem with alcohol and/or drugs? Y N

j. Do you have mental health problems? Y N

k. When was your last visit to a physician (medical doctor)? _____

l. Do you have a physician (medical doctor)? Y N

If yes please provide the Name, Address and Telephone _____

_____

DOCTOR'S COMMENTS _____

_____

_____

_____

next page please

DENTAL HISTORY

1. What is the reason for your dental visit? _____

_____

_____

2. Have you ever had any problems following dental treatment? Y N
   If yes, please explain _____
3. Have you ever had a bad or unusual reaction to local anesthetic? Y N
4. Have you ever had a severe injury to your face, teeth or jaws? Y N
5. Have you ever had surgery in your mouth or on your lips? Y N
6. Have you ever had periodontal treatment to your gums? Y N
7. Have you ever had orthodontic treatment to straighten your teeth? Y N
8. Have you ever had extraction (pulling) of any teeth? Y N
9. Have you ever had endodontics (root canals) on any teeth? Y N
10. Have you had any missing teeth replaced by a removable denture, fixed bridge, or an implant? Y N
11. Have you ever worn a bitesplint/nightguard? Y N
12. Have you had a recent toothache? Y N
13. Are your teeth sensitive to hot, cold or pressure? Y N
14. Do you have bleeding gums? Y N
15. Do you have trouble chewing? Y N
16. Do you clench or grind your teeth? Y N
17. Do you have difficulty opening your mouth as wide as you would like? Y N
18. Do your jaw joints or muscles hurt or does your jaw ever lock? Y N
19. Does your jaw click, pop or lock when you chew? Y N
20. Do you experience a dry mouth? Y N
21. Do you have sores in or around your mouth? Y N
22. Please circle the amount of sugar in your diet. Small Moderate High
23. When was the last time you were examined by a dentist? _____
24. Date of most recent radiographs _____
25. How often do you brush? _____
26. How often do you use dental floss? _____
27. Who was your previous dentist? _____
28. Are you satisfied with the appearance of your teeth? Y N
    If No, why not? _____
29. Do you have any questions, concerns, or additional information you would like us to know before we treat you? Y N
    If Yes, please specify _____
30. How do you feel about going to the dentist (please circle) Scared Apprehensive No Problem

DOCTOR'S COMMENTS _____

_____

_____

I certify that to the best of my knowledge the above information is complete and accurate.

Patient signature _____ Date _____

Patient signature _____ Date _____