Donald L. Ridgell, D.M.D.

PRACTICE LIMITED TO PROSTHODONTICS

Date_____

Name _____ Date of Birth _____

Name wish to be called _____ Marital Status _____

Address _____ Home Phone _____

City_____ State _____ Zip Code_____

Social Security # _____ E-Mail Address_____

Student _____ School _____

Employer_____ Address _____

Occupation _____ Work Phone_____ Cell_____

Name of Spouse_____ Employer _____

Person Responsible for Payment _____

Address _____

Family Physician _____ Date of Last Medical Exam_____

Previous Dentist _____ Date of Last Dental Exam _____

Who Referred You to This Office _____

What dental problem caused you to seek treatment at this office? Explain _____

_____

Preferred Day of Appointments_____ Time _____ AM/PM_____

---------- **Confidential Medical History**----------

Are you now or have you recently been under a physician's care? Reason _____

_____

Have you ever been a patient in a hospital or had any serious illness? Explain _____

_____

Circle any of the following which you have had or suspected:

Cancer or Tumors	Tuberculosis	Prolonged Bleeding	Rheumatic Fever	Severe Infections
Diabetes	High/Low Cholesterol	Heart Trouble	Frequent Thirst	Severe Headaches
Heart Murmur	Kidney/Bladder Trouble	Epilepsy	High/Low Blood Pressure	Anemia
Thyroid Disease	Chest Pain	Lung Disease	Glaucoma	Venereal Disease
Stroke	Pneumonia	Radiation Treatment	Shortness of Breath	Fainting Tendency
Asthma or Hay Fever	Blood Diseases	Tonsils Removed	Sinus Trouble	Liver Disease
Mental Disorders	Hepatitis or Jaundice	Slow Healing	AIDS/HIV Positive	Other

Are you taking any medications? (list) _____

Medication: Dosage (mg and # per day): _____ Action: _____

_____ _____

Are you allergic to or suffer ill effects from: (circle)

Penicillin Codeine Nitrous Oxide Aspirin Sedatives Other

Women Only: Are you pregnant? Yes/No How many months?

Please turn over and complete the back of this form.

Are you breast feeding your child? Yes/No

Do you have any problems associated with your menstrual period? Yes/No

Are you presently taking any medicine of any kind routinely? (Hormones, Birth Control pills, etc.) Yes/No

If yes, what _____

Signature of Patient or Guardian _____ **Date** _____

Signature of Witness _____ **Date** _____

Please Indicate Below How You Prefer to Pay for Your Dental Treatment

Cash _____ **Personal Check** _____ **MasterCard/Visa** _____

Do you have dental insurance? Y/N - If yes complete form below.

Insured Name _____ **Insured Date of Birth** _____

Insured Social Security # _____ **Subscriber ID#** _____

Employer Providing Insurance _____

Insurance Company Name _____

Other Insurance? _____

If yes, Insured Name _____ **Insured Birth Date** _____

Insured Social Security # _____ **Employer Providing Insurance** _____

Insurance Company Name _____