NICK RIDDER, DDS, MS

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New Patient Information
ADULT

Today's Date:________________________

Patient's Name____
LAST FIRST MI

Home Address ____

Phone ______________________ Date of Birth ________________ Age _______________

Work Phone _________________ Cell Phone __________________ Sex: Female Male

Contact email ____

Patient's Dentist _______________________________ Last visit date ___________________

Referred by ____

Employer ________________________________ Work Phone __________________________

Spouse's Name ___________________________ Spouse's Employer_____________________

Marital Status: married separated divorced remarried widowed single

Name & Ages of Children in family____

____

Main concern(s) for today's appointment: _____________________________________

____

Medical History

Diabetes	Y	N	Hay Fever	Y	N	HIV	Y	N
Heart Trouble	Y	N	Asthma	Y	N	Tonsillitis	Y	N
Rheumatic fever	Y	N	Allergies	Y	N	Hepatitis	Y	N
Bone disorders	Y	N	Convulsions	Y	N	Endocrine-thyroid	Y	N
Abnormal bleeding	Y	N	ADD/ADHD	Y	N	Epilepsy	Y	N

Any other medical concerns?

____

List any drugs or medications currently taking:

_______________________________________ Why? _________________________________

_______________________________________ Why? _________________________________

Are you allergic to any medications? ____

Are you allergic to? LATEX METALS/NICKEL PLASTICS

Have tonsils and adenoids been removed? ______________ Do you snore? ______________

Have there been any injuries to the face, mouth or teeth? ___________________________________
Did you ever suck thumb or fingers? ________________ Until what age? _____________________
Do you have any problems with speech? ____
Have you been informed of any missing or extra permanent teeth? ___________________________
Have you had any previous orthodontic examinations? _____________________________________
Were any x-rays taken? ____
Are you especially apprehensive towards dental visits? _____________________________________
Do you have any congenital abnormalities? ____
Do you have any of the following habits? MOUTH BREATHER NAIL BITING
LIP SUCKING/ BITING TONGUE THRUST

TMJ History

Have you had any discomfort or clicking in the jaw-joints near the ears? ______________________
Do you clench or grind your teeth? ____
Do you have frequent head or neck aches? ____
Do you have pain or ringing in the ears? ____
Has your jaw ever locked or slipped out of place? ____
Are your teeth sore or sensitive? ____

Insurance Information

Person Responsible for Account ____
LAST FIRST MI
Relationship to Patient ____________________________ Date of Birth _____________________
Address (if different than patient) ____
Home Phone ____________________________________ SS #_____________________________
Employer _______________________________________ Occupation _______________________
Business Address _________________________________ Business Phone ___________________
Insurance Company _______________________________ Insurance Phone ___________________
Insurance Company Address ____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of patient Date

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

____
Signature of patient Date

Doctor/Staff Signature _________________________________ Date _____________
Nick Ridder, DDS, MS