Michael D. Ryan DDS PC

Welcome to our office. We will do our best to make your appointments as convenient and pleasant as possible. If at any time you have any questions regarding treatment, appointments or fees, please feel free to ask. This will help us to serve you better.

Patient's Name ____________________________ M F Age _____ Date of Birth _________
Address __________________________________ City _____________ Zip Code___________
Home Phone # ( )________________ Bus. Phone # ( ) _______________
Cell Phone # ( )__________________ Email Address _________________________________
SS # ___________________________
Family Status Single ____ Married ____ Divorced ____ Widowed____
Who will be responsible for this account____

If patient is a child:
Father's Name ______________________________ Work/Cell Phone #( )________________
Mother's Name ______________________________Work/Cell Phone #( )_______________

Primary Dental Insurance

Subscriber Name ___________________________________Relationship to patient __________
SS# ___________________________ Employer_____________________________________
Date of Birth ____________________ Address______________________________________
Plan/Group Name ___________________________ Group No# ___________________
Insurance Co. ___________________________________ Phone # ( )____________________
Address ____

Secondary Dental Insurance

Subscriber Name ___________________________________Relationship to patient __________
SS# ___________________________ Employer_____________________________________
Date of Birth ____________________ Address______________________________________
Plan/Group Name ___________________________ Group No# ___________________
Insurance Co. ___________________________________ Phone # ( )____________________
Address ____

I authorize this office to print my insurance forms and to use this signature authorization in lieu of my personal signature. I hereby authorize payment to be directly sent to this office.

____
Signature of patient (parent if minor)

Continued on other side

Medical History

1. Date of last physical examination ______________________________
   A. Are you now under the care of a physician? Yes No (please circle one)
   B. If so, for what condition? ______________________________
2. Family physician: Name ______________________________
   Address ______________________________City ______________________
   Phone Number (   )______________________

3. Are you taking any type of drugs or medication? Yes No (please circle one)
   A. If so, what? ______________________________
____

4. Have you ever had any of the following:

	(Please circle one)	
a. Rheumatic fever	Yes	No
b. High blood pressure	Yes	No
c. Heart valve damage or replacement	Yes	No
d. Asthma or hay fever	Yes	No
e. Fainting spells or epilepsy	Yes	No
f. Diabetes	Yes	No
g. Kidney or liver disease	Yes	No
h. Tuberculosis	Yes	No
i. Anemia or blood disease	Yes	No
j. Tonsils and / or adenoids removed	Yes	No
k. Radiation treatments	Yes	No
l. Delayed or abnormally slow healing	Yes	No
m. Hepatitis	Yes	No
n. AIDS or HIV infection	Yes	No
o. Thyroid problems	Yes	No
p. Respiratory problems, emphysema, bronchitis	Yes	No
q. Arthritis or painful swollen joints	Yes	No
r. Stroke	Yes	No
s. Ulcers	Yes	No
t. Sinus problems	Yes	No
u. Malignancies (cancer)	Yes	No
v. Blood transfusion	Yes	No
w. Circulation problems	Yes	No
x. Psychiatric care	Yes	No
5. Women - Are you pregnant?	Yes	No

6. Are you allergic or have you had a reaction to:

a. Local anesthetics	Yes	No
b. Penicillin or other antibiotics	Yes	No
c. Aspirin	Yes	No
d. Latex	Yes	No
e. Codeine or other narcotics	Yes	No

Dental History

1. When was your last dental visit? ______________________________
2. When was the last time x-rays were taken? ______________________________
3. Which dentist has x-rays? ______________________________
   Address ______________________ City ____________________
4. Have you ever had any problems associated with dental treatment? ______________

____

The information provided is complete and correct to the best of my knowledge. I agree to inform this office of any changes in my medical or dental health.

______________________ ______________________________

Date Signature