RIDGE COMMONS

FAMILY DENTISTRY

4100 S Ridge Rd Suite 103 | McKinney, TX 75070 | P: (972) 972-8782 | F: (972) 972-8784 | hello@rcfdentistry.com

Thank you for choosing us for your dental care.

So that we may better assist you, please fill out this form as completely as you can. If you have any questions, please let us know.

PATIENT INFORMATION

CONFIDENTIAL

Please provide us with a copy of your ID and insurance card for verification.

Name _____(_____)
Last First Middle Preferred Name

Sex: □ M □ F Birthdate _____ SSN _____

Please check appropriate box: □ Minor □ Single □ Married □ Other

If minor, parent/guardian's name _____

Address _____ City _____ State _____ Zip _____

Home #_____Cell #_____Other # _____

Email address_____

Preferred method of appointment reminders? □ Text □ Email □ Call

Occupation _____Employer/School Name_____

Person to contact in case of an emergency_____ Phone #_____

Relationship to the patient _____

Pharmacy Name_____ Phone #_____

Whom may we thank for referring you? _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Reason for leaving _____

Check (✓) if you have had problems with any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaws
□ Food collection between teeth
□ Snore or have sleep apnea
□ Teeth Grinding
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to sweet, hot/cold, or biting
□ Sores/growths in mouth
□ Yellow or discolored teeth
□ Dissatisfied with teeth/appearance
□ Other
(please specify) _____
_____

How often do you floss? _____ How often do you brush? _____

Have your wisdom teeth been extracted? □ Yes □ No

Are you nervous about dental treatment? □ Yes □ No

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MEDICAL INFORMATION

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Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).
□ Yes □ No

Have you or anyone in your family had malignant hyperthermia or other complications while under general anesthesia?
□ Yes □ No

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe _____
Have you ever had a blood transfusion? □ Yes □ No If yes, give date(s)_____
Do you have Poryphyria (blood disorder)? □ Yes □ No
Are you on blood thinner (i.e Warfarin, baby Aspirin,etc)? □ Yes □ No

Gender Specific Questions:
Are you pregnant or could be pregnant? □ Yes □ No
Are you Nursing? □ Yes □ No
Are you taking birth control pills? □ Yes □ No

Check (✓) if you have had problems with any of the following:

□ Anemia	□ Cortisone Treatments	□ Hepatitis	□ Scarlet Fever
□ Arthritis, Rheumatism	□ Cough, Persistent	□ High Blood Pressure	□ Shortness of Breath
□ Artificial Heart Valves	□ Cough up blood	□ HIV/AIDS	□ Skin Rash
□ Artificial Joints	□ Diabetes	□ Jaw Pain	□ Stroke
□ Asthma	□ Epilepsy	□ Kidney Disease	□ Swelling of Feet/Ankle
□ Back Problems	□ Fainting	□ Liver Disease	□ Thyroid Problems
□ Blood Disease	□ Glaucoma	□ Mitral Valve Prolapse	□ Tobacco Habits
□ Cancer	□ Headaches	□ Pacemaker	□ Tonsillitis
□ Chemical Dependency	□ Heart murmur	□ Radiation Treatment	□ Tuberculosis
□ Chemotherapy	□ Heart Problems	□ Respiratory Disease	□ Ulcer
□ Circulatory Problems	□ Hemophilia	□ Rheumatic Fever	□ Venereal Disease

Medications *(please list medications you are currently taking)*

_____
_____
_____

Allergies *(please list if any)*

_____
_____
_____

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and health information on this date and verify that all information reported to Ridge Commons Family Dentistry is correct. I understand that undisclosed medical information and current medications, allergies, or illness are risk factors.

_____ _____
Please print name of Patient Date

_____ _____
Signature of Patient or Parent/Legal Guardian Relationship to Patient