THOMAS J. RITTER, D.D.S.

HEALTH HISTORY

NAME ______ Single ______ Married ______ Divorced ______ Separated ______ Widowed

RESIDENCE ADDRESS ______ CITY ______ STATE ______ ZIP ______

WORK PHONE ______ HOME PHONE ______ SOCIAL SECURITY NUMBER ______

CELL PHONE ______ EMAIL ADDRESS ______

EMPLOYED BY ______

PRESENT POSITION ______ HOW LONG HELD ______

WHY DID YOU CHOOSE OUR OFFICE? ______

NAME OF YOUR DENTAL INSURANCE COMPANY ______

It is important that I know about your dental and medical history. Many things have a direct bearing on your dental health. I will review the questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

MEDICAL HISTORY

PHYSICIAN'S NAME ______ Date of last physical exam ______

Birthdate ______ Age ______

Do you have or have you had any of the following. Please indicate with check mark (√).

______	Any heart problems	______	Allergies to anesthetics	______	Hepatitis	______	Sinus Problems
______	High blood pressure	______	Allergies to medicines or	______	Herpes	______	Stroke
______	Low blood pressure	______	drugs (explain below)	______	Malignancies	______	Typhoid Fever
______	Circulatory problems	______	Allergies to	______	Measles	______	Tonsillitis
______	Nervous problems	______	Anemia	______	Mumps	______	Tuberculosis
______	Radiation treatments	______	Arthritis	______	Psychiatric care	______	Ulcer
______	Excessive bleeding	______	Asthma	______	Rheumatic Fever	______	Other
______	Pos. HIV Test	______	Diabetes	______	Scarlet Fever		

Are you pregnant ______ Blood pressure: S ______ /D ______ / ______

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment.

List any medications you are currently taking.

______

______

______

______

Date ______ Your Signature ______ Other side, please.

DENTAL HEALTH QUESTIONNAIRE

1. Are you having any discomfort at this time? ______
2. Brief dental history ______
3. When were your most recent x-rays and where? ______
4. Do you have any missing teeth? Have they been replaced? ______
5. Are your teeth sensitive? To what? ______
6. Describe your maintenance of your mouth at home, the type of brush and frequency. ______
   brush floss stimudents rubber tip tooth pick
7. Do your gums ever bleed? When? ______
8. Do you grind or clench your teeth? ______
9. Does food ever get wedged between your teeth? ______
10. Does your jaw ever pop, click or hurt? ______
11. Do you ever have headaches? How often? What part of your head? ______
12. Have you had gum treatments, braces or any out of the ordinary dental treatment? ______
13. Do you feel you may have bad breath or a bad taste in your mouth? ______
14. Do you currently or have ever smoked cigarettes? ______
15. Do you have any fear of dentistry? ______
16. What do you feel the overall condition of your mouth is? ______
17. Have you ever had an unpleasant dental experience that you wish to discuss with the Dr.? ______
18. Do you like the way your smile looks? ______

NOTES