Fred T. Ridge, D.D.S. — Patient Information Sheet

115 Turnberry Way • Pinehurst, NC 28374 • (910) 695-3100 • Fax (910) 695-3126

Patient Name	
Patient Account No.	Medical Alert

What is the reason for your visit today?_____

_____

Date of Last Dental Visit_____Last Dental Cleaning_____Last Full Mouth X-rays_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____

Address_____State_____Zip_____

Telephone_____

How often do you have dental examinations?_____

How often do you brush your teeth?_____How often do you floss?_____

What other dental aids do you use? (Interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No

If yes, please describe_____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Have you noticed any bad odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other lesions?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If yes, please describe, including cause

_____

Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where?_____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Do you:			Are you satisfied with your teeth's appearance?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	Would you like to keep all of your teeth all of your life?	Yes	No
Bite your lips or cheeks regularly?	Yes	No	Do you feel nervous about having dental treatment? If so, what is your biggest concern?_____ _____	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, nails, fingernails)	Yes	No	Have you ever had an upsetting dental experience? If yes, please describe_____ _____	Yes	No
Mouth breathe while awake or asleep?	Yes	No			
Have tired jaws, especially in the morning?	Yes	No			
Smoke / chew tobacco?	Yes	No			

MEDICAL HISTORY

Patient Name	
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years?.....Yes No
   If yes, for what?_____
   Physician's Name_____Phone_____
   Address_____City_____State_____Zip_____
2. Have you taken any medication or drugs during the past two years.....Yes No
3. Are you taking any medication, drugs or pills now?.....Yes No
4. Have you ever taken any of the following: Yes No Fen-Phen (Fenfluramine-Phenpermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues?.....Yes No
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?.....Yes No
   If yes, please list_____
6. Have you been a patient in the hospital during the past five years?.....Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores / Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis / Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Troubles	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special / Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous / Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric / Psychological Care	Yes	No

8. Have you ever been diagnosed with sleep apnea?.....Yes No
9. Do you use more than two pillows to sleep?.....Yes No
10. Have you lost or gained more than 10 pounds in the last year?.....Yes No
11. Do you have or have you had any disease, condition, or problem not listed?.....Yes No
    If yes, please list_____
12. **Women:** Are you: **Pregnant?** Yes, _____**Months** No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health or medication.

Patient / Guardian Signature _____ Date_____

History Review _____

_____

_____

Dentist Signature _____Date_____