RYAN SPEIRS, DMD

Today's Date: _____ **E-mail Address:** _____ Preferred Method of Appt Reminder ☐ phone ☐ email ☐ text

Name: _____ ☐ **Male** ☐ **Female**
Last First Middle

Birth Date: _____ / _____ / _____ **Age:** _____ **Social Security #:** _____ (For Insurance/ Office Use ONLY)

Home Address: _____
Street/P.O. Box City State Zip

Home Phone #: _____ **Cell #:** _____ **Work #:** _____

Are you an existing patient? ☐ **Yes** ☐ **No** **If not, whom may we thank for referring you?** ☐ Another patient **Name:** _____
☐ Dental Office ☐ Drive by ☐ Phonebook ☐ School ☐ Work ☐ Other

Employer: _____ **How Long there?** _____ **Occupation:** _____

Employer's Address: _____
Street/P.O. Box City State Zip

SPOUSE OR EMERGENCY CONTACT INFORMATION

His / Her Name: _____ **Birth Date:** _____/_____/_____ **Relationship:** _____

Home Phone #: _____ **Work #:** _____ **Ext.:** _____

MEDICAL HISTORY / HEALTH INFORMATION

Have you ever had any of the following? If so, please check the box:

☐ ....Acid Reflux	☐ ....Diabetes: **Type 1 / 2**	☐ ....Heart Disease	☐ ....Nervous Disorder	☐ ....Stomach Problems
☐ ....Alcohol Abuse	☐ ....Dizziness	☐ ....Hepatitis: **A B C**	☐ ....Osteoporosis	☐ ....Stroke
☐ ....Artificial Joints	☐ ....Drug Abuse **Meth / Other**	☐ ....High Blood Pressure	☐ .... Pacemaker	☐ ....Thyroid Disorder
☐ ....Artificial Valves	☐ ....Emphysema	☐ ....HIV+ / Aids	☐ .... Psychiatric Problems	☐ ....Tobacco Use
☐ ....Asthma	☐ ....Epilepsy	☐ ....Kidney Problems	☐ .... Radiation Treatment	☐ ....Tuberculosis (TB)
☐ ....Blood Disease	☐ ....Excessive Bleeding	☐ ....Liver Disease	☐ .... Respiratory Problems	☐ ....Tumors
☐ ....Cancer	☐ ....Fever Blisters	☐ ....Low Blood Pressure	☐ ....Seizures	☐ ....Ulcers
☐ ....Chemotherapy	☐ ....Heart Attack	☐ ....Lupus	☐ ....Sinus Problems	☐ ....Other_____ ....

For Women: Are you Pregnant? ☐ Unsure ☐ Yes ☐ No Week #: _____

Please list any serious medical condition(s) that you have experienced: _____

_____

Please list all prescription medications that you are currently taking. If none, please check the box → ☐ **NONE**

_____

_____

_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex	☐ Sedatives	☐ Tetracycline
☐ Barbiturates	☐ Dental Anesthetics	☐ Jewelry / Metals	☐ Penicillin	☐ Sulfa Drugs	☐ Other _____

How would you rate your fear of dental treatment? ☐ Low ☐ Moderate ☐ High

AUTHORIZATION

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered. As a courtesy, we will file your dental insurance as an out of network provider.

_____ Date: _____
Signature of patient, parent / guardian