

# North Ridgeville Dental



Providence Square  
34155 Center Ridge Road  
N. Ridgeville, Ohio 44039

Cell phone # \_\_\_\_\_  
E-Mail address \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Patient's address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Patient's employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Employer's Phone: ( ) \_\_\_\_\_ Soc. Sec No.: \_\_\_\_\_ Years worked: \_\_\_\_\_

Marital status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed  
Spouse's Name: \_\_\_\_\_ Soc. Sec No.: \_\_\_\_\_  
Spouse's Employer: \_\_\_\_\_ Employer's Phone: ( ) \_\_\_\_\_  
In Case of Emergency Contact Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

### IF SPOUSE OR GUARDIAN IS LIABLE FOR ACCOUNT FILL IN THE FOLLOWING

Responsible Party's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Party's Employer: \_\_\_\_\_ Years Employed? \_\_\_\_\_ SS# \_\_\_\_\_  
Dental Insurance? ( ) Yes ( ) No  
Name of Company: \_\_\_\_\_  
Family Doctor's Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Last Physical: \_\_\_\_\_

If you have or have had any of the following, please check

- |                              |                             |                  |
|------------------------------|-----------------------------|------------------|
| ( ) Any Heart Problems       | ( ) Hepatitis (Date: _____) | ( ) Pacemaker    |
| ( ) High Blood Pressure      | ( ) Hepatitis Still Active? | ( ) Ulcer        |
| ( ) Low Blood Pressure       | ( ) Stroke                  | ( ) Anemia       |
| ( ) Circulatory Problems     | ( ) Previous Surgery        | ( ) Arthritis    |
| ( ) Nervous Problems         | ( ) Contact Lenses          | ( ) Asthma       |
| ( ) Radiation Treatments     | ( ) AIDS                    | ( ) Diabetes     |
| ( ) Heart Murmur             | ( ) Rheumatic Fever         | ( ) Epilepsy     |
| ( ) Excessive Bleeding       | ( ) Scarlet Fever           | ( ) Tonsillitis  |
| ( ) Allergies to Anesthetics | ( ) Sinus Problems          | ( ) Tuberculosis |

I AM ALLERGIC TO THE FOLLOWING MEDS: \_\_\_\_\_

Are you pregnant? \_\_\_\_\_ Last Dental Exam? \_\_\_\_\_ What was done? \_\_\_\_\_  
Are you having discomfort at this time? \_\_\_\_\_ Bleeding Gums? \_\_\_\_\_  
Have you ever had gum treatment? \_\_\_\_\_ When? \_\_\_\_\_

I am Currently taking the following medications:

	MEDICATION	REASON	TIMES PER DAY
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
2.	_____	_____	_____

I certify that I have answered all the questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information regarding my treatment or my child's treatment to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance may pay less than the actual bill. I agree to be responsible for the payment of all services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_