Welcome!
We would like to get to know you better!

DATE_____

NAME_____
NAME I GO BY_____
DATE OF BIRTH_____/_____/_____
MARITAL STATUS_____
NAME OF SPOUSE_____
RESIDENCE_____
_____ ZIP_____
PHONE_____
CELL PHONE_____
SOCIAL SECURITY #_____-_____-_____
E-MAIL ADDRESS_____

OCCUPATION_____
EMPLOYER_____
ADDRESS_____
_____
PHONE_____

CLOSEST RELATIVE_____
PHONE_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?_____

NOTES:

DEDICATED TO YOU AND YOUR SMILE

PREVENTIVE, GENERAL & COSMETIC DENTISTRY FOR TODAY'S FAMILY

Dr. Harris L. Rittenberg
5417 Ortega Blvd
Jacksonville, FL 32210
(904) 384-4391
www.drrittenberg.com

M E D I C A L

Your answers are for our records only and will be considered confidential.

Do you have a personal physician? Yes No
Physician's name_____
Phone_____
Approximate date of your last exam:
_____/_____/_____
Your current physical health is
Good Fair Poor
Are you currently under the care of any physician?
Yes No
If yes, please explain:
_____
_____
_____
Do you smoke or use tobacco in any other form?
Yes No
Are you presently taking any drugs prescribed by a physician or dentist? Yes No
If yes, please list:
_____
_____
_____
Have you had any serious medical problems in the last 5 years? Yes No
If yes, please explain: _____
_____
_____

FOR WOMEN:

Are you pregnant?	**Y**	**N**
Are you nursing?	**Y**	**N**
Taking birth control pills?	**Y**	**N**

(antibiotics can alter the effects of BCP's)

PREMEDICATION WITH ANITBIOTICS MAY BE NEEDED FOR THE FOLLOWING:

Have you ever had...?

Joint replacement Yes No
(If yes, what?_____ when?_____)
Prosthetic heart valves Yes No
Previous endocarditis Yes No
Heart transplant Yes No
Specific rare congenital heart diseases Yes No
If yes, please list_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Heart Trouble	Y	N	**Cancer/Chemotherapy**	Y	N
Heart Attack/Stroke	Y	N	**HIV+/AIDS**	Y	N
Heart Murmur	Y	N	**Immune System problems**	Y	N
Rheumatic Fever	Y	N	**Drug/Alcohol Abuse**	Y	N
Pacemaker/ arrhythmia	Y	N	**Sexually transmitted diseases**	Y	N
Hi/Lo Blood Pressure	Y	N	**Chronic Hepatitis**	Y	N
Joint Replacement	Y	N	**Abnormal bleeding**	Y	N
Blood Disorder	Y	N	**Psychiatric problems**	Y	N
Respiratory problems	Y	N	**Sinus problems/ Allergies**	Y	N
Kidney problems	Y	N	**Epilepsy/Seizures/Fainting**	Y	N
Thyroid problems	Y	N	**Tuberculosis**	Y	N
Diabetes	Y	N	**Stomach Ulcers/ Hyperacidity**	Y	N
Arthritis					

Any others not listed above: _____
_____
_____

Are you allergic to (i.e., itching, rash, swelling of hands, feet, or eyes) or made sick by:
PENICILLIN ASPIRIN CODEINE
METALS(Nickel) OTHER_____
_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medications change, I will inform the dentist without fail.

SIGNATURE_____

Submit Reset

Why have you come to the dentist today?
_____
_____
The approximate date of your last dental visit?
_____
Have you had a full mouth series of x-rays in the past 3 years? Y N
Why did you leave your last dentist? _____
_____
Are your teeth sensitive to:
☐**Heat?** ☐**Cold?**
☐**Sweets?** ☐**Biting pressure?**
Does food catch between your teeth? Y N
Do your gums bleed when brushing? Y N
Have you noticed any gum swelling around any teeth? Y N
Do you have an unpleasant taste or odor in your mouth? Y N
Do you grind your teeth? Y N
Are there any changes you would like in the appearance of your teeth? Y N
Would you like whiter teeth? Y N
Do you feel you will eventually lose your teeth? Y N
If so, at what age?_____
What, if anything, has kept you from visiting the dentist on a regular basis?
☐**Fear** ☐**Pain** ☐**Time** ☐**Money**
☐**Other_____**
_____