# Timothy T. Ryan D.D.S and Associates

## PERSONAL INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ E-mail: _____

Status: ☐ Single ☐ Married Do you have dental insurance? Yes ☐ No ☐

Emergency Contact: _____ Phone #: _____

## MEDICAL HISTORY

Are you currently under medical treatment? Yes No

If so for what? _____

(Women Only) Are you:
Pregnant? **Y/N**
Nursing? **Y/N**

Do you smoke/chew/vape? Yes No

Do you use alcohol? Yes No

Please circle all that apply:

Anemia
Arthritis, Rheumatism
Artificial Heart Valves
Artificial Joints Hip/Knee Date _____
Asthma, Breathing Problems/COPD
Autoimmune Disease (HIV/Aids, Lupus etc.)
Back problems
Bleeding abnormally, with extractions or surgery
Blood Disease
Cancer
Type: _____
When diagnosed: _____
Chemical Dependency
Cortisone Treatments
Cough-persistent or bloody
Dementia/Alzheimers
Diabetes
Emphysema
Epilepsy
Fainting or Dizziness
Glaucoma
Headaches
Heart Murmur
Heart Problems
Hepatitis-Type
Herpes
High Blood Pressure
High Cholesterol
Intestinal Disease
Jaundice
Jaw Pain
Latex Sensitivity
Kidney Disease
Liver Disease
Mitral Valve Prolapse
Nervous Problems
Pacemaker
Psychiatric Care
Radiation/Chemotherapy
Respiratory Disease
Rheumatic Fever
Scarlet Fever
Sinus Trouble
Skin Rash
Stroke
Swelling
Swollen Neck Glands
Thyroid Problems
Tonsillitis
Tuberculosis
Tumor or growth on head/neck
Ulcer

## MEDICATIONS AND ALLERGIES

List all prescriptions and supplements:

_____

_____

_____

_____

Are you allergic to any of the following:
Aspirin
Barbiturates (sleeping pills)
Codeine
Enviromental/Seasonal
Iodine
Latex
Local Anesthetic
Sulfa
Other: _____

## DENTAL HISTORY

Date of last dental visit: _____
Bad breath **Y/N**
Bleeding gums **Y/N**
Chew on side of mouth **Y/N**
Clicking or popping jaw **Y/N**
Dry mouth **Y/N**
Grinding teeth **Y/N**
Gums swollen or tender **Y/N**
Loose teeth **Y/N**
Orthodontic treatment **Y/N**
Periodontal treatment **Y/N**
Sensitivity or tooth pain **Y/N**
How often do you floss: _____
How often do you brush: _____

## SureSmile

Would you like to change anything about your smile? We offer SureSmile, a clear aligner therapy.
**Y/N**

Would you like to change anything with your overall appearance?
**Y/N**

## AUTHORIZATION/SIGNATURE

I authorize the above doctor and/or any provider of services in this office to release the information
required to secure the payment of benefits.

Signature of responsible party: _____Date:_____