SPECTRUM
FAMILY DENTISTRY
RYAN LE & ASSOCIATES, D.D.S., P.A.
8511 CANTILEVER WAY, SUITE #101, RALEIGH, NC 27613
PH: 919-278-7576 FAX: 919-429-8311

Date_____

Patient Information

○ Mr. ○ Mrs. ○ Ms. ○ Dr. First Name_____ M.I.___ Last Name_____ Nickname_____
Sex: ○ Male ○ Female Birthdate_____ Age_____ Soc. Security_____-_____-_____ Email_____
Street_____ City_____ State_____ Zip_____
Home Tel(____)_____ Cell(____)_____ Referred by_____
Dentist_____ Medical Doctor_____ Driver's Lic_____
Employer_____ Bus Tel(____)_____
Emergency Contact: Name_____ Relationship_____ Ph(____)_____

Account Information

Who will be responsible for your account? ○ Self, skip this section ○ Spouse ○ Father ○ Mother ○ Other _____
Name_____ Soc. Security_____-_____-_____ Birth Date _____ Age_____ Tel(____)_____
Street_____ City_____ State_____ Zip_____
Employer_____ Bus Tel(____)_____
Student: ○ Full-Time ○ Part-Time School Name_____ School Address_____
Marital Status: ○ Married ○ Divorced ○ Legally Separated ○ Widow ○ Single _____
Employed: ○ Full-Time ○ Part-Time ○ Retired

Dental Information

Reason for today's visit: ○ New patient exam ○ Emergency ○ Consultation
Are you in pain? ○ Yes ○ No If yes, what activity causes the pain?_____ For how long?_____
Do you require premedication? ○ Yes ○ No ○ Don't know

Please indicate any of the following problems by checking off the corresponding box:

○ Discomfort, clicking or popping jaw	○ Red, swollen or bleeding gums	○ Sensitive teeth or gums	○ Blisters/sore in or around mouth
○ Lost/broken fillings	○ Teeth grinding, clenching	○ Ringing in the ears	○ Broken/chipped tooth
○ Stained teeth	○ Locking jaw	○ Bad breath	○ Burning tongue/lip
○ Difficulty closing jaw	○ Swelling/lumps in mouth	○ Loose/shifting teeth	○ Food caught in between teeth
○ My teeth are sensitive to: ○ Hot ○ Cold ○ Sweets ○ Biting		○ Other_____	

Previous dentist: Name_____ Phone(____)_____
Last dental exam: Date_____ Last dental x-rays: Date_____
Times a day you brush?_____ Times a day you floss_____ Type of toothbrush bristles you use: ○ Soft ○ Medium ○ Hard
How would you rate your smile? (worst) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (best)

Medical Information

Are you taking any of the following medication or drugs? ○ Anti-anxiety ○ Pain ○ Muscle relaxant ○ Stimulant ○ Blood thinner ○ Insulin
○ Marijuana ○ Cocaine Other_____
Do you have or have had any of the following diseases, medical conditions or procedures?

Y N	Y N	Y N	Y N	Y N
○ ○ Heart attack/stroke	○ ○ Thyroid problems	○ ○ Cancer/tumors	○ ○ Cosmetic surgery	○ ○ Heart surgery/pacemaker
○ ○ Kidney problems	○ ○ Shingles	○ ○ X-ray or cobalt tx	○ ○ Heart murmur	○ ○ Liver problems
○ ○ Hepatitis	○ ○ Chemotherapy	○ ○ Rheumatic Fever	○ ○ Respiratory prob	○ ○ HIV / AIDS / ARC
○ ○ Asthma	○ ○ Mitral Valve prob	○ ○ Sinus Problems	○ ○ Arthritis	○ ○ Difficulty breathing
○ ○ Artificial valves	○ ○ Stomach ulcers	○ ○ Artificial joints	○ ○ Diabetes	○ ○ Heart disease
○ ○ Psychiatric prob	○ ○ Emphysema	○ ○ Leukemia	○ ○ Cong Heart Defect	○ ○ Venereal disease
○ ○ Fainting/seizures	○ ○ Anemia	○ ○ Chest pains	○ ○ Alcohol/drug abuse	○ ○ Severe/freq headaches
○ ○ High blood press	○ ○ Bleeding prob	○ ○ Scarlet fever	○ ○ Tuberculosis	○ ○ Neck pain
○ ○ Low blood press	○ ○ Nervousness	○ ○ Jaw problems	○ ○ Back prob	○ ○ Glaucoma

Please list any other medical condition you have or ever had: _____
Are you allergic to the following? ○ Latex ○ Penicillin ○ Tetracycline ○ Aspirin ○ Sulfa ○ Dental anesthetics ○ Other_____
Do you use tobacco? ○ Yes ○ No Packs/day?____ For how long?_____ Have you ever taken the drug Phen-Fen or Redux? ○ Yes ○ No
Please rate your general health: (worst) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (best)

For women only:
Are you taking birth control pills? ○ Yes ○ No Are you pregnant? ○ Yes ○ No, How far along?_____ Are you nursing? ○ Yes ○ No

I authorize SFD to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and is correct and current to the best of my knowledge. I understand it is my responsibility to inform SFD of any changes to the information I have provided.

Print Name_____ Signature_____ Date_____