RYE
DENTAL ASSOCIATES

Please complete both pages of this form.
Email to info@ryedental.com
Fax to 914-967-8172

WELCOME to our office. Our goal is to help you reach and maintain maximum oral health.
Please help us to help you by providing the following necessary information:

❒ Mr. ❒ Mrs. ❒ Miss ❒ Ms. ❒ Dr.

Name _____

Address _____

_____

Occupation _____

Date of Birth _____

Home Phone ( ) _____

Bus. Phone ( ) _____

Cell Phone ( ) _____

E-Mail Address _____

Billing Name and address (If different) _____

_____

Referred by ❒ Online Search ❒ Practice Website ❒ Review Website ❒ Social Media ❒ Print Ad

❒ Dentist/Doctor (specify) _____ ❒ Personal referral (specify) _____

Do you have dental insurance? Yes ❒ No❒

If yes, which family member is the policy holder? _____

Dental History

Are you presently in pain or have you been in the past few weeks? Yes ❒ No ❒

Approximate date of your last dental visit _____

Was all work completed at that time? Yes ❒ No ❒

Are your present fillings and/or bridges satisfactory? Yes ❒ No ❒

Do your gums bleed? Yes ❒ No ❒ If yes, when? _____

What would you like done at this visit? _____

_____

Payment is due in full at the time of treatment unless prior arrangements have been made.

Please complete the Medical History on the other side of this page

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Medical History

Name _____

Your physician's name and phone number _____

Are you now under a physician's care? Yes ❒ No ❒

If yes, for what? _____

Are you taking any medication? Yes ❒ No ❒

If yes, please list: _____

Are you allergic to any medication? Yes ❒ No ❒

If yes, please list: _____

For women: Are you pregnant? Yes ❒ No ❒

Have you ever had any of the following diseases or medical problems:

Heart Attack	Yes ❒ No ❒	Diabetes	Yes ❒ No ❒
Stroke	Yes ❒ No ❒	Arthritis	Yes ❒ No ❒
Heart Murmur	Yes ❒ No ❒	Cancer/Chemotherapy	Yes ❒ No ❒
Prolapsed Valve	Yes ❒ No ❒	HIV+/AIDS	Yes ❒ No ❒
Heart Surgery	Yes ❒ No ❒	Tuberculosis	Yes ❒ No ❒
Pacemaker	Yes ❒ No ❒	Radiation Therapy	Yes ❒ No ❒
Hepatitis	Yes ❒ No ❒	Hip/Knee/Heart Valve replacements	Yes ❒ No ❒
Anemia	Yes ❒ No ❒	Any other serious problems - please list below:	Yes ❒ No ❒
High/Low Blood Pressure	Yes ❒ No ❒		
Excessive Bleeding	Yes ❒ No ❒		
Rheumatic Fever	Yes ❒ No ❒		
Asthma	Yes ❒ No ❒		

_____

_____

_____

_____

Have you ever been told by your physician that you require antibiotics before dental treatment?
Yes ❒ No ❒

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ _____

Signature *Date*