RyanSavageDDS
Innovative Dental Care

Cosmetic and General Dentistry
Orthodontics for Adults and Teens

(714) 997-8497
www.ryansavagedds.com

7630 East Chapman Avenue, Suite A, Orange, CA 92869

PLEASE ANSWER EACH QUESTION & COMPLETE BOTH SIDES

Separated ☐ Widowed ☐
Divorced ☐ Single ☐
Child ☐ Married ☐

PATIENT INFORMATION

NAME _____ BIRTHDATE _____ SEX _____

SOC. SEC. NO. _____ HOME PHONE ( ) _____ CELL PHONE ( ) _____

ADDRESS _____ CITY _____ ZIP _____

E-MAIL ADDRESS _____

SCHOOL (If full time student) _____ CITY _____

PREVIOUS DENTIST _____ CITY _____ LAST VISIT _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME (Head of Household) _____ RELATIONSHIP TO PATIENT _____

OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____

EMPLOYER _____ BIRTH DATE _____ PHONE ( ) _____

NAME (Spouse of Head of Household) _____

OCCUPATION _____ SOC. SEC. NO. _____ DRIVER'S LIC. NO. _____

EMPLOYER _____ BIRTH DATE _____ PHONE ( ) _____

ACKNOWLEDGMENT & AUTHORITY

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, X-ray, or other studies that may be used by the attending doctor, or his/her qualified designate.

I also acknowledge full responsibility for the payment of such services, whether I have insurance coverage or not, and I agree to pay for them, in full, at the time of service, unless other arrangements are made. I am responsible for attorney's fees, collection fees, or court costs incurred in the collection of a delinquent account.

Signed: Patient, Parent or Agent _____ **Date:** _____

Relationship to Patient _____

FOR PATIENTS WITH DENTAL INSURANCE

INSURED PERSON'S NAME _____ BIRTHDATE _____

INSURANCE COMPANY _____ GROUP NO. _____ UNION/LOCAL NO. _____

INSURED PERSON'S NAME (If dual) _____ BIRTHDATE _____

INSURANCE COMPANY _____ GROUP NO. _____ UNION/LOCAL NO. _____

INSURANCE RELEASE

AUTHORIZATION TO PAY AND TO RELEASE INFORMATION: I hereby authorize insurance benefit payments directly to Ryan Savage, D.D.S., for his services. I am financially responsible for the charges not covered. A copy of this authorization shall be as valid as the original. I also authorize Ryan Savage, D.D.S., to release to the insurance company any information acquired in the course of examination or treatment relating to my insurance claim.

Signed: Patient, Parent or Agent _____ **Date:** _____

Relationship to Patient _____

PLEASE COMPLETE REVERSE SIDE

PATIENT HEALTH HISTORY

HOW WOULD YOU DESCRIBE YOUR HEALTH? _____ DATE OF LAST MEDICAL EXAM _____

NAME OF PHYSICIAN _____ CITY _____ PHONE _____

WHAT IS YOUR BLOOD PRESSURE? _____

YES	NO	
☐	☐	Are you now or have you been under the care of a physician within the past two years? _____
☐	☐	Are you pregnant? Month _____
☐	☐	Are you now or have you recently been taking any medication? What kind? _____
☐	☐	For what disease? _____
☐	☐	Do you snore? Who else in your household snores? _____
☐	☐	Have you experienced any ill effects or allergy to any medication? (penicillin, novocaine, codeine, aspirin) _____
☐	☐	Do you grind or clench your teeth?
☐	☐	Have you been instructed to wear a night guard?
☐	☐	Do you wear the night guard? If yes, how many nights per week? _____
☐	☐	Have you had any major surgery or hospitalization? _____ Date _____
☐	☐	Are you having any dental pain or discomfort at this time? _____
☐	☐	Have you had any bad dental experiences in the past? _____
☐	☐	Do you smoke or vape anything? If so, what and how often? _____

When was your last dental exam? _____ Was there recommended treatment? _____

How can we help you? _____

If you could change anything about your smile or teeth, what would it be? _____

HAVE YOU HAD?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Emphysema	☐	☐	AIDS	☐	☐	Cold Sores
☐	☐	Heart Disease or Attack	☐	☐	Tuberculosis (TB)	☐	☐	HIV Positive	☐	☐	Genital Herpes
☐	☐	Congenital Heart Defect	☐	☐	Latex Allergy	☐	☐	Hepatitis A (infectious)	☐	☐	Epilepsy or Seizures
☐	☐	Artificial Heart Valve / Stent	☐	☐	Asthma	☐	☐	Hepatitis B (serum)	☐	☐	Stroke
☐	☐	Angina / Chest Pains	☐	☐	Hay Fever	☐	☐	Hepatitis C	☐	☐	Fainting / Dizzy Spells
☐	☐	Congestive Heart Failure	☐	☐	Sinus Trouble	☐	☐	Liver Disease	☐	☐	Nervousness or
☐	☐	Heart Pacemaker	☐	☐	Diabetes	☐	☐	Yellow Jaundice	☐	☐	Panic Attacks
☐	☐	Heart Murmur	☐	☐	Thyroid Disease	☐	☐	Blood Transfusion	☐	☐	Psychiatric Treatment
☐	☐	Rheumatic Fever	☐	☐	Cancer	☐	☐	Anemia	☐	☐	Bleeding Gums
☐	☐	Mitral Valve Prolapse	☐	☐	Radiation Treatment	☐	☐	Sickle Cell Disease	☐	☐	Tooth Pain
☐	☐	Heart Surgery	☐	☐	Chemotherapy	☐	☐	Leukemia	☐	☐	Pain in Jaw Joints
☐	☐	Kidney Trouble	☐	☐	Prolonged Cortisone Therapy	☐	☐	Hemophilia	☐	☐	Bad Breath
☐	☐	Ulcers / Digestive Problems	☐	☐	Glaucoma	☐	☐	Drug Addiction	☐	☐	Chronic Headaches
☐	☐	Arthritis	☐	☐	Contact Lenses	☐	☐	Syphilis	☐	☐	Chronic Neck Aches
☐	☐	Artificial Joint	☐	☐	Dialysis	☐	☐	Gonorrhea	☐	☐	Migraines
☐	☐	Organ Transplant	☐	☐	Bisphosphonate Medications	☐	☐	Fen-Phen	☐	☐	Heart Burn/Acid Reflux
☐	☐	Do You Pre-Medicate for Appointments			(examples are Fosamax, Actonel, and Boniva)	☐	☐	Sleep Apnea	☐	☐	GERD

Reviewed By: _____

Have you advised us of all medical problems of which you are aware? ☐ **YES** ☐ **NO**

If No, Please Explain:

_____

_____

_____

List Medications:

_____

_____

_____

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 medicines change I will inform this office at the next appointment without fail.

Date _____ Signature of Patient, Parent or Guardian _____

Relationship to Patient _____