NATHAN JOHN SAYDYK, DDS, LLC

GENERAL DENTISTRY
Preventive Care
Crowns, Bridges
Dentures
Tooth Colored Fillings
Root Canals
In-house Oral Surgery

COSMETIC DENTISTRY
Whitening / Bleaching
Porcelain Veneers
Cosmetic Bonding & Reconstruction

480-926-0776

936 E. Williamsfield Road, Suite 102 Gilbert, Arizona 85296

Please complete the following Patient Registration and Confidential Health History

1 Step — *If the appointment is for **you**, Please Start Here*

Today's Date

Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Work Phone # | Cell or Pager # *(if applicable)*

Driver License # | Birth Date | SS#

☐ Single ☐ Married ☐ Divorced ☐ Widowed | E-Mail Address

2 Step — *Insurance Information*

Group #

Dental Insurance Company | Phone #

Street Address

City | State | Zip Code

Employer | Phone #

Insured Employee Name | Birth Date

Date Employed | Insured Employee SS#

1 Step — *If the appointment is for **your child**, Please Start Here*

Todays Date

Child's Name | Sex

Street Address

City | State | Zip Code

Home Phone # | Birth Date | Age

School | Grade

3 Step — *Person Financially Responsible for Account*

Name

Address | City | State | Zip

Home Phone # | Work Phone # | Ext #

SS# | Drivers License #

Employer

Work Address | City | State | Zip

Spouse's Name

Employer | Work Phone # | Ext #

Work Address | City | State | Zip

4 Step — Getting to Know You

Referred to us by…or how did you hear about StoneRidge Dental?

Your Hobbies and Interests

Is a member of your family a patient in our office? ☐ Yes ☐ No

Their Name

Address City State Zip

5 Step — Emergency Contact Information

Name of an individual you would like us to contact in an emergency?

Address City State Zip

Home Phone # Work Phone # Ext #

Closest Relative ***not*** living with you?

Address City State Zip

Home Phone # Work Phone # Ext #

6 Step — Office Policies and Health Consent; Please Read:

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by benefits) are due and payable at the time or service. Full explanation of financial policies are detailed on the StoneRidge Dental Financial Policy form included in the new patient folder.

I agree to review and abide by those policies detailed in the StoneRidge Dental Financial Policy. _____ Initials _____ Date

For the professional services rendered to me or my minor child or ward by the dentist, I agree to pay the reasonable value of services to said dentist or his assignee at the time services are rendered, or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fee if suit is instituted hereunder to collect monies owed by me, including interest, processing fees or commissions that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including dental benefit companies and other group health plan benefits otherwise payable to the undersigned, to Dr. Nathan John Saydyk.

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined therein.

I certify that the answers to the health questions are accurate and correct to the best of my knowledge and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Nathan John Saydyk and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent (s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include, but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as a part of dental treatment, including preventive procedures of basic dentistry, teeth, gums and surrounding tissues may remain sensitive or possibly quite painful both during and after completion of treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions, and have been informed of alternative treatment options that are avaliable.

7 Step — Please Sign Below

Signature of Patient, Parent or Guardian | *Date* | *Relationship to Patient*

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications _____		
3. heart problems _____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure _____	☐	☐
9. a stroke _____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema _____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol _____	☐	☐
23. diabetes _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐

ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6.	Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS			
7.	Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8.	Have you ever whitened (bleached) your teeth? _____	☐	☐
9.	Are you self conscious about your teeth? _____	☐	☐
10	Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT			
11.	Do you / would you have any problems chewing gum? _____	☐	☐
12.	Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14.	Are your teeth crowding or developing spaces? _____	☐	☐
15.	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	☐	☐
16.	Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
17.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18.	Do you have tension headaches or sore teeth? _____	☐	☐
19.	Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE			
20.	Have you had any cavities within the past 3 years? _____	☐	☐
21.	Do you have a dry mouth? _____	☐	☐
22.	Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23.	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24.	Do you avoid brushing any part of your mouth? _____	☐	☐
25.	Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE			
26.	Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27.	Have you ever experienced gum recession? _____	☐	☐
28.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29.	Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30.	Are your teeth becoming loose? _____	☐	☐
31.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32.	Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____