Welcome to the Office of Steven P. Ray, D.D.S., P.A

11811 Hinson Road, Suite 200
Little Rock, AR 72212
Tel: (501) 312-1127

Patient Information

☐ New Patient ☐ Existing Patient Update Date: _____

☐ Single: ☐ Married: ☐ Partnered: ☐ Divorced: ☐ Separated: ☐ Widowed: ☐ Male ☐ Female

Last Name: First: Middle: Social Security No.

Street Address: Home Phone

City: State: Zip: Cell Phone

Date of Birth Who may we thank for referring you? Work Phone

E-Mail Address: Best time to reach you? Other family members seen by us?

Employer How Long There Occupation

Employer's Address

Emergency Information

In case of accident notify: Relationship Home Phone

Cell Phone Work Phone Address

Responsible Party Information

Name Date of Birth Social Security No.

Employer Work Phone Drivers License Number;

Insurance Information

Company Name Telephone Number Group/Policy Number

Address

Insured's Name Relationship Date of Birth Social Security Number

Insured's Employer & Address Phone

Dental History

Former Dentist: _____ Date of Last X-Rays: _____

City, State: _____ How Often Do You Floss? _____

Date of Last Dental Visit: _____ How Often Do You Brush? _____

Please Check All That Apply:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on Lips or Mouth
- ☐ Finger Nail Biting
- ☐ Grinding Teeth
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth or Broken Fillings
- ☐ Orthodontic Treatment
- ☐ Pain Around Ear
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Frequent Headaches
- ☐ Jaw, Head or Neck Injuries
- ☐ Jaw Difficulty: Clicking and/or Pain
- ☐ Tooth Pain

Medical History

Physician's Name: _____ Date of Last Visit: _____

	YES	NO
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medications?	☐	☐

Please List: _____

_____

	YES	NO
4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine, or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:	YES	NO
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Other	☐	☐

8. (Women Only) Are you:		
Pregnant?	☐	☐
Nursing?	☐	☐
Taking Birth Control pills?	☐	☐

Please Check All That Apply:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Chronic Fatigue Syndrome
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough - Persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis - Type
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Latex Sensitivity
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet / Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on Head/Neck
- ☐ Ulcer
- ☐ Venereal Disease

Assignment and Release

I affirm that the information I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence as per Dr. Steven P. Ray's Privacy Policy. I acknowedge that is my responsibility to inform this office of any changes in my medical status. i authorize the dental staff to preform the necessary dental services I may need.

I certify that I am covered by the insurance policy and company listed on the reverse side of this form and I assign to Dr. Steven P. Ray all insurance benefits otherwise payable to me. I understand that I am responsible for payment of all servic renered and also responsible for paying any co-payment and deductivle that my insurance does not cover. I hereby authorize Dr. Ray or his representative to release all informaiton necessary to secure the payment of benefits. I authorize the use of this siguature on all my insurance submissions, whether maunal or electric.

Signature: _____ Date: _____