RENODENTAL ASSOCIATES

Patient's Name _____ Age _____ Birthdate ____ /___ /____ Sex M _____ F _____
Address _____ Phone # ( ) _____
City _____ State _____ Zip _____ SS # _____
Employer _____ Occupation _____ Phone # ( ) _____ Years _____
Spouse _____ Occupation _____ Employer _____ Phone # ( ) _____
Email Address: _____
Financially responsible person _____ Bank _____SS# _____
In case of emergency, contact _____Phone # ( ) _____
Dental Insurance Co. _____ Effective date _____
Have you used your dental insurance this year? _____ Policy # _____ Group # _____
Physician _____ Previous Dentist _____
Referred by _____
Pharmacy_____ Phone # ( ) _____

DENTAL HISTORY

I. Circle Appropriate Answer

1. Yes No Are you happy with your smile, and are you satisfied with the overall condition of your mouth?
If no, what would you like to improve? _____Appearance, _____Chewing ability, _____Pain
2. Yes No Have you experienced bleeding gums?
3. Yes No Have you experienced tender gum tissue?
4. Yes No Do you grind your teeth?
5. Yes No Do you suffer from frequent headaches?
6. Yes No Are your jaws frequently sore?
7. Yes No Have you experienced sensitive teeth?
8. Yes No Have you experienced sinus problems?
9. Yes No Have you had problems with prior dental treatment?
If yes, what, _____
10. Yes No Are you in pain now? If yes, how long? _____

MEDICAL HISTORY

II. Circle Appropriate Answer

1. Yes No Has there been a change inyour health within the last year?
2. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why_____
3. Yes No Are you being treated by a physician now? For what? _____

Date of last medical exam? _____ Date of last dental appt? _____

III. Have you experienced the following:

4. Yes No Chest Pain (angina)?
5. Yes No Shortness of breath?
6. Yes No Recent weight loss, without dieting?
7. Yes No Persistent cough, coughing up blood?
8. Yes No Dry Mouth?
9. Yes No Heart Disease?
10. Yes No Tumors, cancer?
11. Yes No Heart murmurs/MVP?
12. Yes No Rheumatic fever?
13. Yes No Stroke, hardening of arteries?
14. Yes No High blood pressure?
15. Yes No TB, emphysema, other lung diseases?
16. Yes No Hepatitis, other liver diseases?
17. Yes No Kidney, bladder disease?
18. Yes No Family history of diabetes, heart problems, tumors?

19. Yes No Fainting spells?
20. Yes No Excessive thirst?
21. Yes No Frequent urination?
22. Yes No Bleeding problems, bruising easily?
23. Yes No Seizures and/or epilepsy?
24. Yes No Any autoimmune disorders (RA, Sjogren's, etc.)?
25. Yes No Diabetes?
26. Yes No Human Immunodeficiency Virus (HIV)?
27. Yes No Eye diseases?
28. Yes No Skin diseases?
29. Yes No Anemia?
30. Yes No VD (syphilis or gonorrhea)?
31. Yes No Herpes?
32. Yes No Thyroid, adrenal disease?
33. Yes No Allergies?
Penicillin: _____
Latex: _____
Other: _____

IV. Have you had or currently have:

34. Yes No Radiation treatment?
35. Yes No Chemotherapy?
36. Yes No Prosthetic heart valve? Date: ____/____/____
37. Yes No Blood transfusions? Date: ____/____/____
38. Yes No Been diagnosed with Osteoporosis?
39. Yes No Recent hospitalization?
40. Yes No Artificial joint?
41. Yes No Surgeries?
42. Yes No Pacemaker?
43. Yes No Psychiatric care?

V. Are you taking or have you previously taken:

44. Yes No Bisphosphonates?
45. Yes No Recreational drugs?
46. Yes No Drugs, medicines, (incl. Aspirin)?
Please list:
_____, _____, _____
47. Yes No Tobacco in any form?
48. Yes No Alcohol?

VI. Women Only:

49. Yes No Are you or could you be pregnant or nursing?
50. Yes No Are you taking birth control pills?

VII. All Patients:

51. Yes No Do you have, or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____
52. Yes No Would you like to discuss anything with the doctor in confidence?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. This is to certify that I, the undersigned, consent to the performing of any treatment deemed necessary, and the use of local anesthetic or analgesia as indicated. I also understand that I am responsible for my own dental bill. My insurance company will be billed by Reno Dental Associates as a courtesy.

Patient/Guardian's Signature _____ Date _____/_____/_____

Recall Review:

1. Patient/Guardian's Signature _____ Date _____/_____/_____

2. Patient/Guardian's Signature _____ Date _____/_____/_____