

Reno Dental Associates, Ltd.

Patient's Name _____ Age _____ Birthdate ____/____/____ Sex M _____ F _____
Address _____ Phone # () _____
City _____ State _____ Zip _____ SS # _____
Employer _____ Occupation _____ Phone # () _____ Years _____
Spouse _____ Occupation _____ Employer _____ Phone # () _____
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 _____

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? _____
11. Yes No Are you sensitive to caffeine (coffee or tea)?

MEDICAL HISTORY

I. Circle Appropriate Answer

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
Why? _____
4. Yes No Are you being treated by a physician now? For what? _____
Date of last medical exam? _____ Date of last dental appt? _____

II. Have You Experienced?

- | | |
|--|--|
| 5. Yes No Chest pain (angina)? | 20. Yes No Fainting spells? |
| 6. Yes No Shortness of breath? | 21. Yes No Excessive thirst? |
| 7. Yes No Recent weight loss, without dieting? | 22. Yes No Frequent urination? |
| 8. Yes No Persistent cough, coughing up blood? | 23. Yes No Bleeding problems, bruising easily? |
| 9. Yes No Dry mouth? | 24. Yes No Seizures and/or epilepsy? |
| 10. Yes No Heart disease? | 25. Yes No Any immune suppression disorders? |
| 11. Yes No Tumors, cancer? | 26. Yes No Diabetes? |
| 12. Yes No Heart murmurs/MVP? | 27. Yes No Arthritis, rheumatism? |
| 13. Yes No Rheumatic fever? | 28. Yes No Eye diseases? |
| 14. Yes No Stroke, hardening of arteries? | 29. Yes No Skin diseases? |
| 15. Yes No High blood pressure? | 30. Yes No Anemia? |
| 16. Yes No TB, emphysema, other lung diseases? | 31. Yes No VD (syphilis or gonorrhea)? |
| 17. Yes No Hepatitis, other liver diseases? | 32. Yes No Herpes? |
| 18. Yes No Kidney, bladder disease? | 33. Yes No Thyroid, adrenal disease? |
| 19. Yes No Family history of diabetes, heart problems, tumors? | 34. Yes No ALLERGIES |
- Penicillin: _____
Latex: _____
Other: _____

III. Have You Had or Have You Taken?

- 35. Yes No Fen/Phen or other weight loss medications?
- 36. Yes No Radiation treatment? Rads: _____
- 37. Yes No Chemotherapy?
- 38. Yes No Prosthetic heart valve? Date: ____/____/____
- 39. Yes No Blood Transfusions? Date: ____/____/____

- 40. Yes No Recent hospitalization?
- 41. Yes No Artificial joint?
- 42. Yes No Surgeries?
- 43. Yes No Pacemaker?
- 44. Yes No Psychiatric care?

V. Are You Taking

- 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:

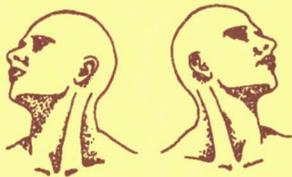
- 1. Patient/Guardian's Signature _____ Date ____ / ____ / ____
- 2. Patient/Guardian's Signature _____ Date ____ / ____ / ____
- 3. Patient/Guardian's Signature _____ Date ____ / ____ / ____
- 4. Patient/Guardian's Signature _____ Date ____ / ____ / ____

VITAL SIGNS

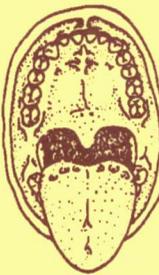
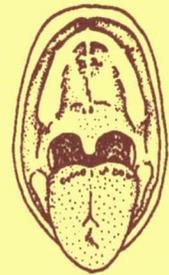
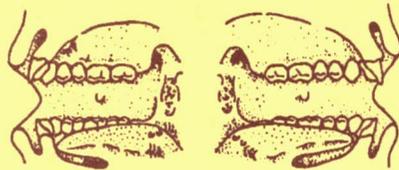
- 1. Blood Pressure: ____ / ____ Pulse / Min: ____ Date: ____ / ____ / ____
- 2. Blood Pressure: ____ / ____ Pulse / Min: ____ Date: ____ / ____ / ____
- 3. Blood Pressure: ____ / ____ Pulse / Min: ____ Date: ____ / ____ / ____
- 4. Blood Pressure: ____ / ____ Pulse / Min: ____ Date: ____ / ____ / ____
- 5. Blood Pressure: ____ / ____ Pulse / Min: ____ Date: ____ / ____ / ____

HEAD AND NECK PHYSICAL EXAMINATION

I. External Structures:



II. Oral Cavity:



Remarks: _____

