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

**Continue**

20. Yes No Fainting spells?
21. Yes No Excessive thirst?
22. Yes No Frequent urination?
23. Yes No Bleeding problems, bruising easily?
24. Yes No Seizures and/or epilepsy?
25. Yes No Any immune suppression disorders?
26. Yes No Diabetes?
27. Yes No Arthritis, rheumatism?
28. Yes No Eye diseases?
29. Yes No Skin diseases?
30. Yes No Anemia?
31. Yes No VD (syphilis or gonorrhea)?
32. Yes No Herpes?
33. Yes No Thyroid, adrenal disease?
34. Yes No ALLERGIES
    Penicillin: _______
    Latex: _________
    Other: ______________________



**Over Please**

**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:**

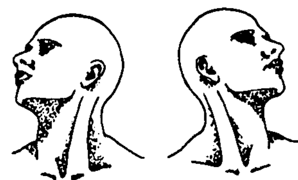
1. Patient/Guardian's Signature ______________________________ Date ______ /______/ ______
2. Patient/Guardian's Signature ______________________________ Date ______ /______/ ______
3. Patient/Guardian's Signature ______________________________ Date ______ /______/ ______
4. Patient/Guardian's Signature ______________________________ Date ______ /______/ ______

## VITAL SIGNS

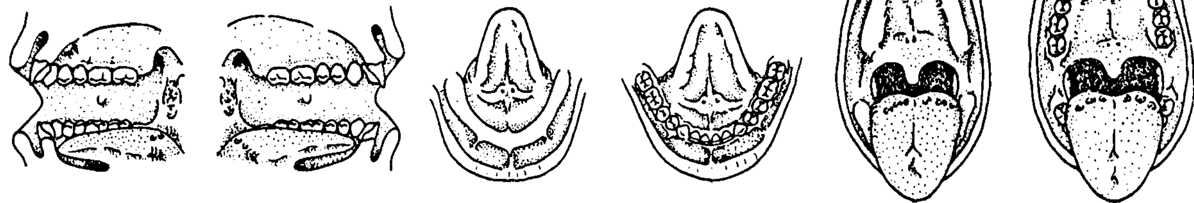
1. Blood Pressure: ________/________ Pulse / Min: ________ Date: _______/_______/_______
2. Blood Pressure: ________/________ Pulse / Min: ________ Date: _______/_______/_______
3. Blood Pressure: ________/________ Pulse / Min: ________ Date: _______/_______/_______
4. Blood Pressure: ________/________ Pulse / Min: ________ Date: _______/_______/_______
5. Blood Pressure: ________/________ Pulse / Min: ________ Date: _______/_______/_______

## HEAD AND NECK PHYSICAL EXAMINATION

**I. External Structures:**



**II. Oral Cavity:**



Remarks:______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________