the Reno dentist

Patient Information

Patient Name: _____ Birth Date: _____
FIRST MI LAST

Social Security #: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street/PO Box Apt. or Unit #

_____
City ST Zip Code

E-mail Address: _____

Employer: _____

Whom may we thank for referring you? Family /Friend Name: _____
☐ Insurance ☐ Location ☐ Event ☐ Mailer ☐ Internet ☐ Facebook ☐ Phonebook

If patient is a minor; Responsible Party Information

Name: _____ Birth Date: _____
FIRST MI LAST

Social Security #: _____ ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Health Information

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV Positive
☐ Anemia
☐ Artificial Joints
☐ Asthma
☐ Cancer
☐ Chest Pain
☐ Chronic/Bloody Cough
☐ Diabetes
☐ Drug Addiction
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting/Dizziness
☐ Fatigue
☐ Glaucoma
☐ Heart Disease
☐ Hepatitis A / B / C
☐ High Blood Pressure
☐ Hoarseness
☐ Kidney/Liver Disease
☐ Loss of Appetite
☐ Night Sweats
☐ Osteoporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Respiratory Problems
☐ Steroids
☐ Snoring Problems
☐ Sleep Apnea
☐ TB
☐ Unexplained Weight loss
☐ Thyroid
☐ Pregnant now?
Due Date: _____
☐ Other: _____

Allergies:
☐ Aspirin
☐ Codeine
☐ Erythromycin
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other: _____

PREMED Y / N (circle one)

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
  Name of Physician: _____ Phone: _____
- Have you been hospitalized in the past 3 years? ☐ Yes ☐ No For What? _____
- Please list any current medications you are taking: _____
- Is there any other medical or dental information you feel I should know about? ☐ Yes ☐ No
  If yes, please explain: _____

DENTAL HISTORY

Please check any of the following that apply to you:

-Sensitivity (hot, cold, sweet, biting) ☐
Where? _____
-Headaches, neck or jaw joint pain ☐
-Mouth ulcers or cold sores ☐
-Teeth or fillings breaking ☐
-Grinding or clenching teeth ☐
-Bleeding, swollen, irritated gums ☐
-Loose, tipped or shifting teeth ☐
-Bad breath ☐

Do you have or have you had any of the following?

-Dentures ☐
-Partial dentures ☐
-Braces ☐
-Gum treatments ☐

Please share the following dates:

-Your last cleaning ____ /____
-Your last oral cancer screening ____ /____
-Your last complete x-rays ____ /____

Name of Previous Dentist

_____

City _____ **State** _____

Phone Number _____

Why did you leave your previous dentist?

_____

	Y	N
If you could whiten your teeth for a cost you could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	Y	N
How much? _____For how long? _____	☐	☐

If you could change your smile, would you:

-Whiten your teeth ☐
-Straighten your teeth ☐
-Close spaces ☐
-Replace metal fillings with tooth colored fillings ☐
-Repair chipped teeth ☐
-Replace missing teeth ☐
-Replace old crowns that don't match ☐
-Have a smile makeover ☐

On a scale of 1–10; 10 being the highest

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____

What is the most important thing to you about your dental visit today?

_____

DENTAL INSURANCE INFORMATION (Primary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

DENTAL INSURANCE INFORMATION (Secondary)		
Insured's Name	DOB	SS#/ID
Insured's Employer		
Insurance Co		
Insurance Co Address		
Phone #		
Group #		

I have reviewed the above information and give authorization to take x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of needs. I give authorization to perform agreed treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.

I authorize the use of any information necessary to process my insurance. I also authorize my insurance company(s) to issue the dental benefits of my plan directly to this office.

X_____ Date: _____
Signature of patient, parent or guardian

X_____ Date: _____
Doctor's Signature

_____
What Matters Most to Patient: