RenovaSmiles
FAMILY & COSMETIC DENTISTRY

Renova Smiles Welcomes you! !!

To help us meet your dental needs, please fill out this form completely in ink. If you have any questions, please ask someone at the front desk and we will be happy to help you.
Thanks for being our patient!

1. Patient Information

Name_____
First Last MI
Preferred Name _____**Title**_____
☐ Male ☐ Female ☐ Child ☐ Single ☐ Married ☐ Other

Date of Birth_____ **SSN**_____
Driver's Lic._____ **State**_____
(Photocopy required)
Address _____
City_____**State**_____**Zip Code**_____
Home Phone _____ **Alternate Phone** _____
E-mail _____ **Alternate E-mail** _____

Occupation_____
Employer_____ **Work Phone**_____
Emergency Contact Name/Phone_____
How did you hear about us?_____

2. Insurance Information

Insured Employee_____ **Insured's Relationship to Patient**_____

Insured's SSN_____**DOB**_____

Insurance Company_____ **Phone**_____

Employer_____**Group #**_____

Is the patient covered by additional insurance? ☐ Yes ☐ No

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above insurance company and assign directly to this office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize this office to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____

Relationship to Patient **Date**

3. Dental History

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

Reason for today's visit_____

Former Dentist_____

Phone_____

Date of last dental exam_____

Date of last dental x-rays_____

Date of last cleaning_____

How often do you brush?_____

How often do you floss?_____

Do you feel pain anywhere?_____

Describe_____

_____

Sensitivity to hot or cold	**Yes**	**No**	Bad breath	**Yes**	**No**
Sensitivity to sweet	**Yes**	**No**	Burning sensation on tongue	**Yes**	**No**
Avoid one side of the mouth when chewing	**Yes**	**No**	Dry mouth	**Yes**	**No**
Sensitivity when biting	**Yes**	**No**	Accident involving jaw	**Yes**	**No**
Broken / cracked fillings	**Yes**	**No**	Clicking or popping jaw	**Yes**	**No**
Food collection between teeth	**Yes**	**No**	Frequent headaches	**Yes**	**No**
Tobacco use	**Yes**	**No**	Grinding teeth	**Yes**	**No**
Gums swollen or tender	**Yes**	**No**	Jaw pain or tiredness	**Yes**	**No**
Gums bleed frequently	**Yes**	**No**	Pain around ear	**Yes**	**No**
Blisters on lips or mouth	**Yes**	**No**	Orthodontic treatment	**Yes**	**No**
Sores or growths inside cheek/in the mouth	**Yes**	**No**	Periodontal treatment	**Yes**	**No**

4. Medical Health History

Physician Name _____ Phone_____

Please list all current medications (include prescription, over-the-counter, herbal supplements) and reason for use:

_____

Are you allergic to the following:

Aspirin Yes No **Erythromycin** Yes No **Tetracycline** Yes No **Codeine** Yes No **Latex** Yes No **Penicillin** Yes No

Please list any other drugs/materials that you are allergic to: _____

Have you had any of the following conditions? ☐ **Artificial joint/valve** ☐ **Heart murmur** ☐ **Mitral valve prolapse** ☐ **Rheumatic fever**

Women Only: Do you use birth control medication? **Yes No** Are you nursing? **Yes No** Are you pregnant? **Yes No** (Due date:_____)

Circle "Yes" or "No" to indicate whether you have had any of the following conditions:

AIDS / HIV	**Yes**	**No**	Convulsions / Epilepsy / Seizures	**Yes**	**No**	Phen-Phen treatment	**Yes**	**No**
Anemia	**Yes**	**No**	Diabetes	**Yes**	**No**	Radiation or Chemotherapy treatment	**Yes**	**No**
Arthritis or Back problems	**Yes**	**No**	Excessive bleeding with surgery/extractions	**Yes**	**No**	Stroke	**Yes**	**No**
Asthma or Respiratory problems	**Yes**	**No**	Heart problems	**Yes**	**No**	Thyroid disorder	**Yes**	**No**
Blood transfusion (Date:_____)	**Yes**	**No**	Hepatitis or Liver problems	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Cancer	**Yes**	**No**	High or Low blood pressure	**Yes**	**No**	Other:	**Yes**	**No**
Cardiac pacemaker	**Yes**	**No**	Kidney problems	**Yes**	**No**			

I, the undersigned, certify that the above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information about my medical or dental history can be dangerous to my health.

_____ _____

X Responsible Party Signature Date

_____ _____

X Attending Dentist Signature Date