**Please answer these questions as best you can. We want to know your special needs so we can give you the best care. Please check the answer that is right for you, “Yes”, “No”, “DK” (Don’t’ Know.) Your answers are confidential and for our records only - - - - BLACK OR BLUE PEN ONLY - - - -**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B \_\_\_\_\_\_\_\_\_\_\_Gender:\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

First M.I. Surname MM/DD/YYYY M/F MM/DD/YYYY

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Work\_\_\_\_\_\_\_\_\_\_\_\_

Parish Postal Code

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

Name Phone

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Self/Spouse/Child

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical**

Yes No DK

**Has/Had** there been a major change to

your health?......................................................

If yes, please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under the care of a physician or are you

receiving ongoing medical care?.....................

Name of your physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last medical visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant/taking birth control? ……..…….

If yes, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you breast feed ……………………………………..……

Do you have any artificial joints, heart valves,

implants, prosthesis, etc.? …………………..……..

Have you ever been told you need to be

pre-medicated prior to dental treatment?.........

Have you had surgery/x-ray treatment/chemotherapy for a tumor, growth, or other condition?...........

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dental**

Yes No DK

Are you having any dental discomfort at

this time? …………………………………………….……..

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had serious trouble with previous dental work? ……………………………………………………………..

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does dental work make you nervous? ………………

Have you ever had any abnormal bleeding associated with previous extractions/ surgery/trauma? ……

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last dental visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a gagger? …………………………………………..

**Other:**

Please check the answer that is right for you, “Yes”,

“No”, “DK” (Don’t Know):

Yes No DK

Do you use tobacco?  What \_\_\_\_\_ Amount\_\_\_\_

Do you smoke?.........  What\_\_\_\_\_ Amount\_\_\_\_

Do you use alcohol?  How Much\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any CURRENT/PAST history of substance abuse?.......................

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Have you had or do you have any of the following?

Please check the answer that is right for you. “Yes”, “No”, “DK” (Don’t Know)

**Heart and Circularity Problems**

Yes No DK Heart Attack ……....….……...☐☐☐

If yes, when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High/Low Blood Pressure.. ☐☐☐

Chest Pain (Angina)….………☐☐☐

Heart Murmur/A fib…………☐☐☐

Artificial Valves/Stents….….☐☐☐

Other Heart Problems………☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No DK

Diabetes – Type I………..…...☐☐☐

Diabetes – Type II …………….☐☐☐

Today’s sugar reading \_\_\_\_\_\_\_\_\_\_

Thyroid Problems……………..☐☐☐

Last Blood Test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Breathing/Lung Problems**

Yes No DK

Hay Fever/Season allergies ☐☐ ☐

Shortness of Breath

From an illness……….…….☐☐☐

Persistent Cough…………….. ☐☐☐

Positive Test/Treatment

For Tuberculosis…………. ☐☐☐

Asthma…………………………... ☐☐☐

Emphysema……………….…… ☐☐☐

Coughing up Blood…………. ☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Problems**

Yes No DK

Rashes……………………………. ☐☐☐

Mole Changes (Size/Color/

Texture)...…………………… ☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Stomach Problems**

Yes No DK

Stomach Pain…………..……...☐☐☐

Heartburn/Gastric Reflux.. ☐☐☐

History of Ulcers………………... ☐☐☐

Colitis…….……………………….. ☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental Health Problems**

Yes No DK

Depression……………………… ☐☐☐

Anxiety………………………….… ☐☐☐

History of Psychiatric

Medications…………….…. ☐☐☐

Bipolar…………………….……… ☐☐☐

Dementia/Alzheimer’s.…... ☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Muscle and Bone Problems**

Yes No DK

Joint/Back Pain……………….. ☐☐☐

Osteoporosis………………….. ☐☐☐

History of Broken Bones…. ☐☐☐

Joint Swelling……..…………… ☐☐☐

Arthritis………………………….. ☐☐☐

Autoimmune conditions

(Lupus /MS/Fibromyalgia) ☐☐☐

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liver**

Yes No DK

Hepatitis A, B, C….…………… ☐☐☐

Alcoholic Liver Disease …... ☐☐☐

Other Liver Diseases……….. ☐☐☐

Jaundice …………………………. ☐☐☐

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Neurologic Problems**

Yes No DK

Epilepsy/Seizures……..…….. ☐☐☐

Chronic Headaches ………… ☐☐☐

History of Head Injury…….. ☐☐☐

Numbness of Arms, Legs,

Hands or Feet……………… ☐☐☐

History of Stroke……..……… ☐☐☐

If yes, when \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fainting Spells…………………. ☐☐☐

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Blood Problems**

Yes No DK

Blood Clots ………….…………. ☐☐☐

Bleeding Problems …………. ☐☐☐

Anemia......…………..…………. ☐☐☐

Aspirin Therapy…….………… ☐☐☐

Hemophilia …………………….. ☐☐☐

Cholesterol …………………….. ☐☐☐

Are you taking Blood

Thinners? …………………… ☐☐☐

If yes, recent INR level \_\_\_\_\_\_\_\_\_

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Other**

Yes No DK

Domestic Abuse …………….. ☐☐☐

Cold Sores………………………. ☐☐☐

Venereal Diseases ………….. ☐☐☐

AIDS/HIV …………….……….…. ☐☐☐

Kidney/Bladder Problems.. ☐☐☐

Frequent Urinary Tract

Infections ………………….. ☐☐☐

Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other disease, condition or problem not

Listed? …………………………… ☐☐☐  
If yes, please explain\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**  Yes No DK

Have you been, and are you taking any **prescribed** or **over-the-counter** medications?

Please list all medications you are taking (Please include prescription and non-prescription medications):

**Medication: Dosage: How Often Taken: Reason for Medication:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies and immunizations**

**Yes No DK Yes No DK**

**Are you allergic to anything?**  **Do you wear a medical alert tag?**

**Are you immunized?**

Please list all allergies/immunizations including reactions:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that, to the best of my knowledge, all the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform this office immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to ReNew Dental Care. I understand that I am responsible for all charges whether or not they are covered by my insurance company.

We set aside time just for you. Appointments not confirmed by 12 noon the business day prior to scheduled appointment is automatically cancelled and removed from the schedule. This allows us to see other patients waiting for an appointment. Cancellations are honored and acknowledged when given between 8:00 a.m. and 5:00 p.m., two business days prior to scheduled appointment. If you miss an appointment, you are required to provide a non-refundable deposit to reserve a subsequent appointment. This deposit will be applied to the rescheduled appointment only.

Eating prior to your dental appointment, unless otherwise instructed, is recommended.

Signature of patient or guardian Date Dentist’s Signature Date