Christopher Reneer DDS

1767 Willow Creek Rd. Prescott, Az 86301

928-541-7979

PATIENT INFORMATION FORM

NAME: ____
LAST FIRST MI PREFERRED NAME

DATE OF BIRTH: ______________________ GENDER (PLEASE CIRCLE): MALE FEMALE

MARITAL STATUS (PLEASE CIRCLE): SINGLE MARRIED DIVORCED WIDOWED

SPOUSE/RESPONSIBLE PARTY'S NAME: ______________________________________

PHYSICAL
ADDRESS:____
STREET APT#

CITY: ______________________________STATE:_______________ZIP:______________

MAILING
ADDRESS: ____
STREET APT#

CITY: ______________________________STATE:_______________ZIP:______________

PHONE: HOME ( )_________________________

WORK ( ) _________________________

CELL ( ) ___________________________

EMAIL ADDRESS: ____

PREFERRED METHOD OF CONTACT (PLEASE CIRCLE): HOME WORK CELL EMAIL

EMPLOYER: _________________________OCCUPATION:______________________

IS IT OKAY FOR US TO CONTACT YOU AT WORK (PLEASE CIRCLE)? YES NO

REFERRED BY: ____

EMERGENCY CONTACT:

NAME: ______________________________RELATIONSHIP:___________________

PHONE: HOME ( ) ________________________

CELL ( )_________________________

REGARDING SCHEDULED APPOINTMENTS:

We respect your time. **When you schedule an appointment with us, this time is reserved exclusively for you.** Any change in this appointment affects many people. If you are unable to keep your appointment, please give us a minimum of 48 hours' notice so that we may offer this time to another patient. We reserve the right to charge $50.00 for a broken, cancelled, or missed appointment with less than 24 hours' notice.

TRANSFER OF RECORDS/COPIES OF X-RAYS:

X-rays and other records may be transferred and/or copied with a minimum of one weeks' notice and a signed records release form. A fee of $25.00-$45.00 will be charged for any records or x-rays copied or transferred. The amount will be determined at the time of request.

PERMISSION FOR TREATMENT:

This is to certify that I, the undersigned, consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable, including the use of local anesthetic and x-rays as indicated. I also acknowledge that any records may be released to specialists I am referred to as needed regarding my care. The information on these forms are correct to the best of my knowledge. I understand that in an effort to minimize the added clerical expense of billing, PAYMENT IS NECESSARY AT THE TIME OF SERVICE.

WE ACCEPT THE FOLLOWING:

CASH CHECK MASTERCARD VISA AMERICAN EXPRESS DISCOVER

PATIENT'S OR
RESPONSIBLE
PARTY'S SIGNATURE: ____

DATE: ______________________________

MEDICAL HISTORY

THE INFORMATION YOU SUPPLY TO THE OFFICE ON THIS FORM, SUBSEQUESNT INTERVIEW BY THE DENTIST, AND ANY INFORMATION RECEIVED FROM YOU PHYSICIAN OR ANY OTHER SOURCE, WILL BE HELD IN THE STRICTEST CONFIDENCE AND WILL NOT BE DISCLOSED WITHOUT YOUR EXPRESS AND WRITTEN PERMISSION.

Patient Name_______________________________________Date_________________________

Physician Name____ Phone #:__________________________________

Date of last visit to Physician________________________ Purpose of visit: ______________________________________

____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (PLEASE LIST DOSAGE AND REASON FOR MEDICATION):____

____

LIST ALL MEDICATION ALLERGIES AND REACTIONS: ____

____

Have you ever taken or are taking any Bisphosphonates (Fosamax Boniva, Actonel, Zometa, Aredia)? Yes / No If Yes, explain: ____

Do you currently take blood thinners (coumadin, asprin, warfarin, etc)? Yes / No If Yes, explain: ____

Do you suffer from any disability? Yes / No If Yes, explain: ____

Have you ever, or are you currently taking Illegal drugs? Yes / No If Yes, explain: ____

Are you HIV positive or have AIDS? Yes / No If Yes, explain/current status: ________________________________

Do you have or have you ever had venereal disease? Yes / No If Yes, explain: ____

Have you ever had an operation or surgery? Yes / No If Yes, explain: ____

Have you ever had a serious injury to your head or neck? Yes / No If Yes, explain: ____

Do you work out or exercise regularly? Yes / No If Yes, what exercises and how often? ________________________

____

Are you on a special diet? Yes / No If Yes, explain: ____

Have you lost weight recently? Yes / No If Yes, explain: ____

Do you or have you ever smoked or used tobacco products? Yes / No If Yes, type /quantity: ______________________________________

Have you consulted/been treated by a psychiatrist, psychologist or counselor? Yes / No If Yes, explain:____

____

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING?
(PLEASE CHECK ALL THAT APPLY)

_____ Abnormal Bleeding
_____ Alcohol Abuse
_____ Anemia
_____Angina Pectoris
_____Artificial Heart Valve
_____Asthma
_____Cancer
_____Chemotherapy
_____Colitis
_____Congenital Heart Disease
_____ Convulsions
_____ Diabetes
_____Difficulty Breathing
_____ Emphysema
_____ Epilepsy
_____ Ulcers

_____ Fainting Spells
_____ Fever Blisters
_____ Frequent Headaches
_____ GERD/ Reflux
_____ Glaucoma
_____ Growths/Tumors
_____ Heart Attack
_____Heart Surgery
_____Hemophilia
_____ Hepatitis A
_____ Hepatitis B
_____ Hepatitis C
_____ High Blood Pressure
_____High Cholesterol
_____ Joint Replacement

_____ Kidney Problems/Renal Dialysis
_____ Liver Disease
_____ Low Blood Pressure
_____ Mitral Valve Prolapse
_____ Pace Maker
_____ Parkinson's Disease
_____ Radiation Therapy
_____ Rheumatism
_____ Seizures
_____ Shingles
_____ Sinus Problems
_____ Sleep Apnea
_____ Stroke
_____ Thyroid Problems
_____ Tuberculosis

WOMEN ONLY

Are you taking Birth Control Pills? Yes / No

Are you pregnant? Yes / No If Yes, # of weeks: ________________________
Due Date: ________________________

Are you nursing? Yes / No

NOTE: A change in your health status should be reported to the office at the earliest possible time.

PERMISSION TO RELEASE HEALTH INFORMATION:

To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to Christopher Reneer DDS to release health/dental information obtained from me and my dental treatment to third party payors, and/ or health practioners.

Patient/Responsible Party Signature: _________________________________Date:__________________

Print Name:____

Relationship to Patient:____

DENTAL HISTORY

Date of last dental visit:________________________ What was it for?:___________________________

When were your last dental Xrays taken? __________________________________

Office/Dentist Name: _____________________________________

Phone Number: ____

In respect to your teeth and any previous dental treatments you have had, please check all that apply:

____abnormal bleeding
____ allergic reaction
____bleeding gums
____catch food between teeth
____cavities
____clench/grind teeth
____clicking/pain In jaw joints
____complications
____dental/perio surgery
____fainting
____fear of dental treatment
____growths/sores in mouth
____gum disease
____jaw muscle pain
____loose teeth
____sensitivity to cold, heat, pressure
____shifting teeth
____spaces between your teeth
____tooth ache
____trouble chewing
____unpleasant dental experience

If yes to any on this page please explain: ____

____

____

Why are you changing dentists? ____

What would you like to accomplish at your visit today? ____

____

Have you ever had an unfavorable reaction to anesthetic? Yes / No If yes, please explain:

____

Have you ever had any serious trouble with any previous dental treatment? Yes / No If yes, please explain:

____

Are you currently undergoing any dental treatment elsewhere? Yes / No If yes, please explain:

____

Have you ever experienced dry mouth? Yes / No If yes, When and how often:

____

How often do you regularly get your teeth cleaned? ____

Have you ever undergone orthodontic treatment? Yes / No

If you have ever had teeth extracted, what was the reason? ____

____

Do you have any dentures or partials? Yes / No If yes, do you wear them? Yes / No

How do you feel about your smile? ____

____

What would be one thing you would change about your mouth/smile? ________________________________

____