



Office of A. Fred Renfro Jr., D.D.S.

Member American Dental Association • Texas Dental Association • Fort Worth District Dental Society
L.D. Pankey Institute • Fellow - Academy of General Dentistry

We are pleased to welcome you to Dr. Renfro's dental practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name (Last Name, First Name, Initial), Address (City, State, Zip), Home Phone, Social Security No., Date of Birth, Patient Employed By, Occupation, Business Address (City, State, Zip), Business Phone, Cell Phone, Sex, M F, Driver's License No., Fax No., E-mail Address, In case of emergency, who should be notified?, Home Phone, Cell Phone, Preferred Appointment Times, Whom may we thank for referring you?

RESPONSIBLE PARTY

Name, Relation to Patient, Birthdate, Social Security No., Address (if different from patient), Phone, City, State, Zip, Occupation/Employer, Business Phone

DENTAL BENEFIT PLAN INFORMATION Is patient covered by a Dental Benefit Plan? [] Yes [] No If yes, please continue

Name of Insured, Relation to Patient, Birthdate, Social Security No., Employer, Insurance Company, Group No., Address (City, State, Zip), Phone, Web Site

FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible care. If you have a dental benefit plan, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of your payment responsibility. Payment for services is due at the time services are rendered. We accept cash, check, and most major credit cards. Returned checks are subject to a \$30.00 returned check charge. If an account becomes delinquent and is referred to a collection agency, a 40% collection fee may be added to the account. We emphasize that as dental care providers, our relationship is with you, not with your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If you have any questions about the above information, please don't hesitate to ask us. We are here to help.

Signature _____ Date _____

Patient, Parent, Guardian

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City _____ State _____

Is your primary source of water from a private well city, name _____

Would you like information for the following services?

- | | | |
|--|--|---|
| <input type="checkbox"/> Athletic Mouthguard | <input type="checkbox"/> Home water fluoride testing | <input type="checkbox"/> Restorative (root canals/crowns/bridges) |
| <input type="checkbox"/> Cosmetic Bonding, Crowns or Veneers | <input type="checkbox"/> Oral Surgery | <input type="checkbox"/> Partial |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Dental Implants | <input type="checkbox"/> Periodontal Treatment (gum disease) | <input type="checkbox"/> TMJ evaluation and/or treatment |
| | | <input type="checkbox"/> Whitening or bleaching |

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physicians's Name _____ Phone No. _____ Date of last visit _____

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, date _____

Please check the following:

- | Yes No | Yes No | Yes No | Yes No |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Hemophilia, clotting | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Alcohol dependency | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, persistant | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Angina, chest pains | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV positive | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> tobacco habit |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Orthopedic Surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Recreational drug use | Describe: _____ |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Respiratory problems | _____ |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Rheumatic fever | |

MEDICATIONS

List any medication you are currently taking
(including non-prescription drugs)

Tylenol Advil Ibuprofen Aspirin

1. _____
2. _____

Pharmacy of choice _____

Phone _____ Fax _____

ALLERGIES

Are you allergic to, or have you had any reactions to the following?

- | Yes No | Yes No | Yes No |
|--|------------------------------------|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Advil, ibuprofen |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Other, list _____ |
| <input type="checkbox"/> Other antibiotics | | |

WOMEN ONLY: Are you pregnant or think you might be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Nursing <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Birth Control Pills/Hormones <input type="checkbox"/> Yes <input type="checkbox"/> No
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AUTHORIZATIONS

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that providing incorrect information can be dangerous to my health. I authorize the dental staff to perform any necessary dental services with my consent that I may need during diagnosis and treatment. To the extent permitted under applicable law, I authorize release of my information relating to any dental benefit plan claim. I authorize payment of the dental benefits otherwise payable to me directly to Dr. Renfro.

Signature _____ Date _____

Our office is committed to meeting or exceeding the standard of infection control mandated by OSHA, the CDC and the ADA.

To better serve our patients, we require a 24-hour notice of an appointment change.

Missed appointments may be assessed a cancellation fee.