

# DENTAL SMILES



Patient's Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Driver's License #: \_\_\_\_\_  
(Circle) Sex: Female Male Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
Physician's Address: \_\_\_\_\_ Doctor's Phone #: \_\_\_\_\_  
Woman: (circle) Pregnant? Yes / No, If yes, How many months are you? \_\_\_\_\_  
Woman: (circle) Nursing? Yes / No, Taking any birth control pills? Yes / no

### ☒ CHECK IF ANY OF THE FOLLOWING:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Aids                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Scarlet Fever           |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Sickle Cell Disease     |
| <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling Of Feet Ankles |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Blood Disease         | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit           |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chemotherapy          | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Circulatory Problems  | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Venereal Disease        |

Describe Heart Disease: \_\_\_\_\_

(CIRCLE) HAVE YOU HAD ANY SERIOUS ILLNESS OR OPERATIONS? YES / NO  
DESCRIBE AND LIST PAST AND CURRENT MEDICAL CONDITIONS:

LIST PAST & CURENT MEDICAL CONDITIONS	LIST MEDICATIONS

List Allergies : \_\_\_\_\_

\_\_\_\_\_.

**I CERTIFY THAT ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT. IF THERE ARE ANY CHANGES IN MY HEALTH CONDITION, AND/OR ANY MEDICATIONS, I WILL INFORM MY DENTIST AT THE NEXT APPOINTMENT.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_