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:**

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