Humble Smiles

Date: _____

Patient Information

Patient's Full Name:_____Nickname:_____

Date of Birth ___/___/____ Age _____ Social Security # _____Marital Status S/M/D/W

Home Address Including Zip Code: _____

Email addresses _____ Best Way to Contact You? Home/Work/Cell/Email/Text

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Occupation _____Employer _____Spouse's Name _____

Person Responsible for Account _____ Who can we thank for referring you? _____

Please present your Driver's License along with Insurance Card to Employee at Front Desk

Although dental personnel primarily treat the area at or around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications you may be taking could have an important interrelationship with the dentistry that you will receive. Thank you for answering the following questions.

Are you under a physician's care now? __yes __no Please explain:_____

Have you ever been hospitalized or had a major operation? __yes __no Please explain:_____

Have you ever had a serious head or neck injury? __yes __no Please explain:_____

Are you taking any medication, pills, drugs, or herbal supplements? __yes __no Please explain:_____

_____

Do you take or have you taken Phen-fen or Redux? __yes __no Please explain:_____

Are you on a special diet? __yes __no Please explain:_____

Do you use tobacco? __yes __no Please explain:_____

Do you use controlled substances? __yes __no Please explain:_____

Women are you: Pregnant/Trying to get pregnant? __yes __no Taking oral contraceptives? __yes __no Nursing? __yes __no

Are you allergic to the following?

__Penicillin __Aspirin __Codeine __Acrylic __Metal __Latex __Local Anesthetics __Other if yes please explain: _____

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Do you have or have had any of the following?

Aids/HIV Positive	Yes/No	Asthma	Yes/No	**Cold Sores/Fever Blisters** Yes/No		Epilepsy or Seizures	Yes/No	Glaucoma	Yes/No
Alzheimer's Disease	Yes/No	Blood Disease	Yes/No	**Congenital Heart Disorder** Yes/No		Excessive Bleeding	Yes/No	Hay Fever	Yes/No
Anaphylaxis	Yes/No	Blood Transfusion	Yes/No	Convulsions	Yes/No	Excessive Thirst	Yes/No	Heart Attack/Failure	Yes/No
Anemia	Yes/No	Breathing Problems	Yes/No	Cortisone Medicine	Yes/No	Fainting or Dizzy Spells	Yes/No	Heart Murmur	Yes/No
Angina	Yes/No	Bruise Easily	Yes/No	Diabetes	Yes/No	Frequent Cough	Yes/No	Heart Pace Maker	Yes/No
Arthritis/Gout	Yes/No	Cancer	Yes/No	Drug Addiction	Yes/No	Frequent Diarrhea	Yes/No	Heart Trouble/Disease	Yes/No
Artificial Heart Valve	Yes/No	Chemotherapy	Yes/No	Easily Winded	Yes/No	Frequent Headaches	Yes/No	Hemophilia	Yes/No
Artificial Joint	Yes/No	Chest Pain	Yes/No	Emphysema	Yes/No	Genital Herpes	Yes/No	Hepatitis A	Yes/No
Hepatitis B or C	Yes/No	High Blood Pressure	Yes/No	Hives or Rash	Yes/No	Hypoglycemia	Yes/No	Irregular Heartbeat	Yes/No
Kidney Problems	Yes/No	Leukemia	Yes/No	Liver Disease	Yes/No	Low Blood Pressure	Yes/No	Lung Disease	Yes/No
Mitral Valve Prolapse	Yes/No	Pain in Jaw Joints	Yes/No	Parathyroid Disease	Yes/No	Psychiatric Care	Yes/No	Radiation Treatment	Yes/No
Recent Weight Loss	Yes/No	Renal Dialysis	Yes/No	Rheumatic Fever	Yes/No	Rheumatism	Yes/No	Scarlet Fever	Yes/No
Shingles	Yes/No	Sickle Cell Disease	Yes/No	Sinus Trouble	Yes/No	Spina Bifida	Yes/No	**Stomach/Intestinal Disease** Yes/No	
Stroke	Yes/No	Swelling of Limbs	Yes/No	Thyroid Disease	Yes/No	Tonsillitis	Yes/No	Tuberculosis	Yes/No
Tumors or Growths	Yes/No	Ulcers	Yes/No	Venereal Disease	Yes/No	Yellow Jaundice	Yes/No	Systemic Lupus	Yes/No

Do you have or have you had any illness that is not listed above? Yes/No

If yes please explain: _____ Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patients) health. **It is my responsibility to inform the dental office of any changes in medical status.**

_____

Signature of Patient/Parent or Guardian Date

I have read the medical history above and agree that it adequately states all past and present conditions.

Exceptions: _____ None ___ Patient's Signature: _____ Date:_____

Exceptions: _____ None ___ Patient's Signature: _____ Date:_____

Exceptions: _____ None ___ Patient's Signature: _____ Date:_____

Exceptions: _____ None ___ Patient's Signature: _____ Date:_____

Exceptions: _____ None ___ Patient's Signature: _____ Date:_____