Only Smiles Dental

Patient Information

Patient Name: _(Last)_____(First)_____ Date:_____

Male___ Female___ Married___ Single ___ Child___ Other___

Social Security Number:_____ Birth Date:_____

Phone (Home):_____ (Cell Phone):_____

Email: _____ Best Time To Call: _____

Address: _____

_____

Emergency Contact (Name, Phone Number):_____

Date of Last Dental Visit:_____ Reason For Today's Visit:_____

Have You Ever Had Any Of The Following? Please Check All That Apply:

	AIDS or HIV Positive		Diet (Restricted)		Kidney Disease		Tumors
	Allergies		Dizziness		Latex Sensitivity		Ulcers
	List:		Emphysema		Liver Disease		Venereal Disease
			Epilepsy		Neurological Disorders		Codeine Allergy
	Anemia		Excessive Bleeding		Pacemaker		Penicillin Allergy
	Anxiety		Fainting		Pregnancy		Other Medication Allergy:
	Arthritis		Glaucoma		Due Date:		
	Artificial Joints		Hay Fever		Psychological Disorders		
	Artificial Heart Valve		Head Injuries		Radiation Treatment		Medications Being Taken:
	Asthma		Heart Disease		Respiratory Problems		
	Blood Disease		Heart Murmur		Rheumatic Fever		
	Cancer		Hemophilia		Rheumatism		
	Cold Sores/Fever Blisters		Hepatitis		Sinus Problems		
	Contact Lenses		High Blood Pressure		Stomach Problems		
	Cortisone Medication		Jaundice		Stroke		
	Diabetes		Dizziness		Tuberculosis		

Have you ever had any complications following dental treatment? Yes___ No ___

If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past 2 years? Yes___ No___

If yes, please explain: _____

Are you now under the care of a physician? Yes___ No___

If yes, please explain: _____

Name of Physician:_____ Phone: _____

Do you have any health problems that need further clarification? Yes___ No ___

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____

How did you hear about our practice?

___ Patient/Friend ___ Patient/Relative ___ Dental Office ___ Online ___ Other: _____