Only Smiles Dental

Patient Information

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

Male___ Female___ Married___ Single ___ Child___ Other___

Social Security Number:_____ Birth Date:_____

Best Phone Where You Can Be Reached: _____ Type Of Phone: Cell ( ), Home ( )

Alternate Phone Number: _____ Type Of Phone: Cell ( ), Home ( )

Best Time To Call: _____ Best Email Where You Can Be Reached: _____

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 In The Box To The Left:

	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 are true and correct. If there are any changes, I will inform the doctor at the next appointment.

Signature: _____ Date: _____

How did you hear about our practice?

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