Date: _____

Patient Name: _____ **D.O.B:** ____/_____/_____ **S.S.N** _____-_____-_____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____
Male □ **Female** □ **Unspecified** □ **Marital Status** (circle): Single /Married / Other

Best contact type: □ Phone call □ Text □ E-mail**:** _____
I agree to have confirmation and reminder texts sent □ YES □ NO I agree to have confirmation and reminder emails sent □ YES □ NO

IN CASE OF AN EMERGENCY, PERSON TO BE CONTACTED:
Name: _____ Relationship: _____ Phone #: _____

HEALTH INFORMATION
Primary Care Physician: _____ **Which Clinic/Hospital:** _____
Y N
□ □ Have you been hospitalized within the past 2 years? If yes, for what? _____
□ □ Are you currently being treated by a physician? If yes, for what? _____
□ □ Are you currently taking any medications or drugs? If yes, please list: _____

_____
□ □ Are there any medical issues that we should know about? (Such as genetic disorders, autoimmune diseases, autism spectrum disorders, or any other condition that could affect dental care not listed elsewhere on this form)

_____
□ □ Do you use any Tobacco products? If yes, what? _____
□ □ Have you ever had an addiction problem with alcohol, drugs, or prescription medications? If yes, explain. _____
_____

Y N Conditions
□ □ High Blood Pressure
□ □ Low Blood Pressure
□ □ High Cholesterol
□ □ Heart surgery-When? _____
□ □ Heart Attack-When? _____
□ □ Stroke-When? _____
□ □ Pace Maker
□ □ Artificial Heart Valve
□ □ Heart Murmur
□ □ Congenital Heart Defect
□ □ Mitral Valve Prolapse
□ □ Rheumatic Fever
□ □ Cancer-What Kind? _____
When? _____
□ □ Chemotherapy
Last Round? _____
□ □ Radiation
Last Round? _____

Y N Conditions
□ □ Asthma/Difficulty Breathing
□ □ Emphysema
□ □ Sinus Problems
□ □ Diabetes: Type I or II
□ □ Osteoporosis/Osteopenia
□ □ Bisphosphonate use
Examples: Boniva, Actonel, Zometa
□ □ Arthritis/Rheumatoid Arthritis
□ □ Artificial Bones/Joints
Date(s): _____
□ □ Abnormal Bleeding (anemia, etc)
□ □ HIV + AIDS
□ □ Liver Disease
□ □ Epilepsy/Seizures
□ □ Hepatitis (A)(B)(C)
□ □ Organ Transplant
When? _____
□ □ Tuberculosis

Y N Conditions
□ □ Acid Reflux
□ □ Thyroid Problems
□ □ Psychiatric Problems
□ □ Hearing Impaired
□ □ Frequent Headaches
□ □ Fainting Spells

Y N Allergies
□ □ Erythromycin
□ □ Aspirin
□ □ Codeine
□ □ Dental Anesthetics
□ □ Seasonal
□ □ Latex
□ □ Metals
□ □ Clindamycin
□ □ Penicillin/Amoxicillin
□ □ Sulfa
Other: _____

FEMALE	
Are you pregnant: ☐ Yes ☐ No **If yes, when are you due?** _____ **How many weeks?** _____	**Are you taking any form of birth control? ☐ Yes ☐ No** **If yes, I understand if given medication this may affect the effectiveness of birth control. INITIAL** _____ **Are you nursing: ☐ Yes ☐ No**

I grant that any information regarding dental/medical care provided by A Lifetime of Smiles may be received by the following people.
Name: **Relationship**

_____
_____

Signature of Patient or Guardian: _____ **Date:** _____

(2 Year Update) Signature of Patient or Guardian: _____ **Date:** _____