SMARTMOUTH DENTAL CARE

Date _____

Name _____Birthdate _____ Male ___ Female ___

Phone Number _____ Email _____

Address _____ City/State/Zip Code _____

SSN _____ Marital Status: M__ S__ W__ D___

Employer _____ How long at current job _____ Job Title _____

When and where are the best times to reach you?_____

Emergency Contact _____ Phone Number/ Relationship _____

Tell Us About You

Who may we thank for referring you?_____

Date of last dental visit?_____Last date of hygiene visit?_____

Insurance

Insurance Carrier _____ID Number _____

Subscriber's Name _____Subscriber's Date of Birth _____

Relationship to Patient _____

Secondary Insurance

Insurance Carrier _____ ID Number _____

Subscriber's Name _____ Subscriber's Date of Birth _____

Relationship to Patient _____

Medical History

Have you ever had any of the following Medical Conditions:

- Abnormal Bleeding
- Artificial bones/joints
- Anemia
- Asthma
- Arthritis
- Blood Transfusion
- Cancer/ Chemotherapy
- Congenital Heart Defect
- Diabetes
- Difficulty breathing
- Sleep Disorder
- Snore
- Drug/alcohol abuse
- Emphysema
- Epilepsy / Seizures / Fainting
- Fever blisters
- Eating Disorder
- Glaucoma
- Ulcers
- Heart murmur
- Cardiovascular Disease
- Heart Surgery / Pacemaker
- Hemophilia
- Hepatitis, Jaundice or liver disease
- High/low blood pressure
- Aids or HIV Infection
- Gastrointestinal Disease
- Heart attack / Strokes
- Kidney Problems
- Mitral valve prolapse
- Mental Health

Please Specify:_____

- Chest Pain upon exertion
- G.E Reflux / Persistent Heartburn

- Radiation treatment
- Rheumatic fever
- Severe headaches
- Shingles
- Sickle Cell Disease
- Sinus problems
- Abnormal Bleeding
- Thyroid problems
- Tuberculosis
- Ulcers/Colitis
- Venereal disease
- Osteoporosis
- Persistent Swollen Gland in Neck
- Arteriosclerosis
- Other_____ _____

- Have you ever taken bisphosphonates? _____
- Have you ever had any injuries to the face, mouth, teeth, or chin? _____
- Have you ever had a serious/difficult problem associated with any previous dental work?_____ If yes, explain:_____
- Do your gums bleed?_____
- Have you ever had any pain/tenderness in your jaw joint?_____
- Do you use or smoke tobacco in any form?_____
- Do you drink alcoholic beverages?_____
- Current physical health_____
- Physicians name and phone number:_____
- Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?_____
- Do you have any disease or condition not listed above that you think we should know about? _____

  Please explain:_____

For Women

- Are you currently pregnant?_____
- Are you taking birth control pills?_____

List Prescriptions and over the counter medications you are currently taking?_____

_____

Allergies

Are you allergic or had a reaction to any of the following:

- Local anesthetics
- Aspirin
- Penicillin or other antibiotics
- Barbiturates, Sedatives, or sleeping pills
- Sulfa Drugs
- Codeine or other narcotics
- Metals
- Latex
- Iodine
- Hay Fever/ Seasonal
- Animals
- Food
- Other_____

Signature _____
Date_____

_____
(Patient, legal guardian or authorized agent of patient)