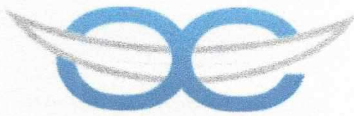

SMILE SOLUTIONS

PATIENT INFORMATION RECORD

Date: ____________________

PATIENT INFORMATION:

Name: ____________________ Date of Birth: ____________ Age: ________

Home Address: ____________________ City: __________ State: ______ Zip: ________

Home Ph #: ______________ Work Ph #: ______________ Cell Ph#: ______________

Email: ____________________ Driver's License Number: ______________

Company/Employer Name: ____________________ Occupation: ______________

Work Address: ____________________ City: __________ State: ______ Zip: ________

SPOUSE:

Spouse's Occupation: ____________________ Spouse Ph #: ______________

Spouse's Work Address: ____________________ City: __________ State: ______ Zip: ________

Who will be financially responsible for this account?____________________

INSURANCE INFORMATION:

Primary Dental Insurance: ____________________

Dental Insurance Primary Subscriber Name: ____________________

Dental Insurance Primary Subscriber ID/Social Security Number: ____________________

Dental Insurance Primary Subscriber Date of Birth: ____________ Group #: ____________

Primary Medical Insurance: ____________________

Medical Insurance Primary Subscriber name: ____________________

Medical Insurance Primary Subscriber ID: ____________________

Medical Insurance Primary Subscriber Date of Birth: ____________ Group #: ____________

- Have you or any member of your family been a patient of our office? ☐ Yes ☐ No
  If Yes, name of prior patient: ____________________
- Name of regular dentist: ____________________ Dentist's Ph #: ______________
- Name of regular physician: ____________________ Physician's Ph #: ______________
- Who can we thank for referring you to our office? ____________________

Date: ______________

HEALTH HISTORY

Patient Name: ______________________________

Age: ________ Height: ________ Weight: ________

ALLERGIES: Are you allergic to or have you had adverse reactions to:

- ☐ Local Anesthesia (Novocain, Lidocaine, etc)
- ☐ Penicillin, Keflex, Clindamycin
- ☐ Other Antibiotics
- ☐ Aspirin, Ibuprofen, Motrin, Aleve, Advil, NSAID
- ☐ Codeine, Vicodin, Darvocet, Percocet
- ☐ Other Prescribed Pain Medication
- ☐ Latex, Tape, or Any Other Materials
- ☐ Metals of Any Type
- ☐ Food Products Including Egg or Soy Products

Please list all known allergies : ______________________________

____

MEDICATIONS: Do you take any of the following?

- ☐ Antibiotics
- ☐ Anticoagulants (Coumadin, Warfarin)
- ☐ Aspirin, Plavix, Motrin, Aleve, Ibuprofen, NSAID
- ☐ Blood Pressure Medications
- ☐ Steroids (Prednisone, Cortisone)
- ☐ Heart or Blood Pressure Medicines

Please list any and all prescribed medications, over-the-counter medications, herbal medications, dietary supplements, or diet medications: ______________________________

____

Answer all questions by checking Yes or No.

- Are you in good health? .... ☐ Yes ☐ No
- Have there been any changes in your health in the past year?.................... ☐ Yes ☐ No
- Are you under a physician's care for a particular problem?.................... ☐ Yes ☐ No
- Have you ever had any serious illnesses, emergency room visits, or hospitalizations?.................... ☐ Yes ☐ No
  If so, please describe: ______________________________
- Have you ever had surgery before?.................... ☐ Yes ☐ No
  If so, please describe: ______________________________
- Did you have any complications with the surgery or with the anesthesia used, including nausea, vomiting, or difficulties with anesthesia?.................... ☐ Yes ☐ No
  If so, please describe: ______________________________
- Do you or ***have you ever taken*** bisphosphonate medications for osteoporosis, cancer, or multiple myeloma (such as Fosamax, Actonel, Boniva, Reclast, Aredia, or Zometa)?.......... ☐ Yes ☐ No
  If so, for how long (months or years)? ______________________________

DO YOU HAVE OR HAVE YOU EVER HAD: Check all that apply.

- ☐ Rheumatic Fever
- ☐ Rheumatic Heart Disease
- ☐ Congenital Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of Breath
- ☐ Seizures
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Fainting/Dizziness
- ☐ Bleeding Disorders
- ☐ Anemia
- ☐ Bleeding Tendency
- ☐ Easy Bruising
- ☐ Blood Transfusions
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Kidney Problems
- ☐ Dialysis
- ☐ Kidney Failure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Acid Reflux
- ☐ Arthritis/Osteoarthritis or Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Heart Valve
- ☐ Hip or Knee Replacement
- ☐ Cancer
- ☐ Radiation Therapy or Chemotherapy
- ☐ Jaw pain/TMJ problems
- ☐ Clenching/Grinding
- ☐ Sleep Apnea
- ☐ Sinus/Nasal problems
- ☐ Immunocompromise
- ☐ Organ Transplant
- ☐ Chronic Pain/Fibromyalgia or Neuropathic Pain
- ☐ Autoimmune Disease (Lupus, Connective Tissue Disease, Others)
- ☐ Alcohol/Chemical Dependency
- ☐ Smoke/Chew Tobacco (_____/Day - Years: ______)
- ☐ Undiagnosed Health Problem (List: ______________________________)

- Any psychiatric diagnosis or other emotional problems? .... ☐ Yes ☐ No
- Any difficulties or serious problems with previous dental treatments? .... ☐ Yes ☐ No
- Any family members that have difficulty with IV or general anesthesia? .... ☐ Yes ☐ No
- Any other concerns or health problems that may affect treatment in our office? .... ☐ Yes ☐ No
- Have you had anything to eat or drink within 6 hours? .... ☐ Yes ☐ No
- Who is driving you home today? Name: ____________________ Ph#: ______________

FOR WOMEN ONLY

- Are you pregnant or is there any chance you may be pregnant? .... ☐ Yes ☐ No
- Are you nursing? .... ☐ Yes ☐ No
- Do you take any oral contraceptives? .... ☐ Yes ☐ No

Signature: ______________________________ **Dr.'s Initials:** ______________