GREAT SMILE DENTAL

PERSONAL INFORMATION

Name: _____

DOB: _____ * SSN: _____

Sex: M F Married___ Single___ Widowed___

Address: _____

Home #: _____ Mobile #: _____

Email: _____

Who can we thank for referring you? _____

INSURANCE INFORMATION

Subscriber Name: _____

DOB: _____ SSN: _____

Carrier Name: _____

ID #: _____

Group #: _____ Contact #: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____

Phone: _____

Only needed if we file dental insurance claims for you or extend credit in any way.

PHYSICIAN INFORMATION

Name of personal physician: _____

Phone: _____

Continuing Care Specialist, if any…

Name: _____

Phone: _____

Reason for care: _____

MEDICAL HISTORY

Approximate date of last physical/check up: _____

Current health condition: ___Excellent ___Good ___Fair ___Poor

Do you have any serious health problems (please circle)? Yes No

If yes, please explain:

_____
_____
_____
_____

WOMEN ONLY

1. Are you pregnant? Yes No

   If yes, how far along? _____

2. Are you nursing? Yes No

3. Are you taking birth control pills? Yes No

MEDICATIONS

Please list ALL prescription medications, dosage, and why you are taking them (feel free to continue on the back of this page if needed):

1. _____

2. _____

3. _____

4. _____

Please list ALL vitamins and supplements you are taking:

_____ _____

_____ _____

_____ _____

Please list all over the counter medications you are taking:

_____ _____

_____ _____

_____ _____

Do you know your blood pressure? Yes No

If yes, what is it? _____

For the following questions, circle ***yes*** or ***no***. Your answers are for our records only and will be confidential.

1. Do you have or have you had any of the following diseases or problems?

    a. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease? Yes No

    b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke, mitral valve prolapse)? Yes No

        i. Do you have inborn heart defects? Yes No

        ii. Do you have a cardiac pacemaker? Yes No

c. Sinus trouble? Yes No

d. Asthma or hay fever? Yes No

i. Do you use an inhaler? Yes No

e. Other respiratory problems? Yes No

f. Fainting spells? Yes No

g. Sleep apnea? Yes No

h. Diabetes or pre-diabetes? Yes No

If yes, specify ____Type I (Insulin dependent) _____ Type II _____ A1C #?

Have you ever had your blood glucose checked? Yes No

i. Hepatitis A, B or C, jaundice, or liver disease? Yes No

j. AIDS or HIV infection? Yes No

k. Thyroid problems? Yes No

l. Arthritis, rheumatoid arthritis or any other autoimmune disorders? Yes No

m. Osteoporosis? Yes No

n. Artificial bones or joints? Yes No

o. Stomach ulcer, GE Reflux, persistent heartburn, hyperacidity? Yes No

p. Kidney trouble? Yes No

q. Tuberculosis? Yes No

r. Persistent swollen glands in the neck? Yes No

s. Tonsillitis? Yes No

t. Chronic pain? Yes No

u. Recurrent infections? Yes No

If yes, please explain: _____

v. Eating disorder? Yes No

w. Epilepsy or other neurological disease? Yes No

x. Mental health disorders? Yes No

If yes, please specify: _____

z. Have you had abnormal bleeding? Yes No

aa. Have you ever had any treatment for a tumor or growth? Yes No

bb. Cancer/chemotherapy/Radiation? Yes No

cc. Do you wear contact lenses? Yes No

dd. Do you have any diseases, conditions, or problems not listed above that you think we should know about? Yes No

If yes, please explain:

_____

_____

_____

Please check if you are **ALLERGIC** to or have a **SENSITIVITY** to any of the following:

___ Local anesthetics
___ Sulfa drugs
___ Codeine/other narcotics
___ Penicillin/other antibiotics
___Aspirin
___Latex
___ Barbiturates, sedatives, sleeping pills
___ Shellfish, iodine or red wine
___ Hay fever/seasonal allergies
___Metals
___Food _____
___Other _____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C virus and Human Immunodeficiency Virus (AIDS). Initial: _____

The information I have given is true and accurate to the best of my knowledge. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ *Date*: _____