

Great Smiles Dental S.C.

MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

Address: _____ Phone: _____

Nickname: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Do you require ANTIBIOTICS before any dental work? Yes No If yes, please explain: _____

Are you taking any BLOOD THINNERS? Yes No If yes, please explain: _____

Are you under a physician's care now? Yes No If yes, please explain: _____

Have you been hospitalized or had any major operations? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications? IF YES, PLEASE LIST Yes No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes, please explain: _____

Do you use tobacco or controlled substances? Yes No If yes, please explain: _____

WOMEN: Pregnant? Yes No

Are you allergic to any of the following?

Aspirin <input type="radio"/> Yes <input type="radio"/> No	Penicillin/Amoxicillin <input type="radio"/> Yes <input type="radio"/> No	Codeine <input type="radio"/> Yes <input type="radio"/> No	Metal <input type="radio"/> Yes <input type="radio"/> No
Latex <input type="radio"/> Yes <input type="radio"/> No	Sulfa Drugs <input type="radio"/> Yes <input type="radio"/> No	Local Anesthetics <input type="radio"/> Yes <input type="radio"/> No	NSAIDS <input type="radio"/> Yes <input type="radio"/> No

Do you have any other allergies that is not listed above? Yes No If yes, please explain: _____

Do you have, or have you had any of the following?

AIDS/HIV <input type="radio"/> Yes <input type="radio"/> No	Cancer <input type="radio"/> Yes <input type="radio"/> No	Heart Attack <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Acid Reflux/GERD <input type="radio"/> Yes <input type="radio"/> No	Cerebral Palsy <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Chemo/Radiation <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Cold sore/Canker sores <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A, B, or C <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Angina (Chest Pains) <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Failure <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Anxiety/Depression <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Sjogren's Syndrome <input type="radio"/> Yes <input type="radio"/> No
Arthritis <input type="radio"/> Yes <input type="radio"/> No	Dialysis <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sleep Apnea <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	Kidney Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Epilepsy/Seizures <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Swelling of the Limbs <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Autism <input type="radio"/> Yes <input type="radio"/> No	Fainting/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Multiple Sclerosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Do you currently have any of the following?

Mouth Breathing/ Dry Mouth <input type="radio"/> Yes <input type="radio"/> No	TMJ/Clicking/ Popping/Pain <input type="radio"/> Yes <input type="radio"/> No	Grinding/Clenching <input type="radio"/> Yes <input type="radio"/> No	Sensitivity <input type="radio"/> Yes <input type="radio"/> No
Broken Teeth <input type="radio"/> Yes <input type="radio"/> No	Bleeding/Swelling/ Irritation <input type="radio"/> Yes <input type="radio"/> No	Previous Periodontal/ Gum Disease <input type="radio"/> Yes <input type="radio"/> No	Hot, Cold, Sweet, Pressure (Circle all that apply.)

Comments: _____

See back side.

AUTHORIZATION FORM

Registration & Medical History Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my/my child's medical status. I authorize this dental staff to perform any necessary dental services that I /my child may need during diagnosis and treatment, with my informed consent.

Financial Agreement

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and responsible for any amount my insurance does not cover. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Great Smiles Dental. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of all information necessary to secure the payment of benefits.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy/been offered a copy of this office's Notice of Privacy Practices.

Acknowledgment of Cancellation Policy
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Out of respect to all of our patients and health care providers, our office has a 24 business hour cancellation policy. This courtesy on your part allows us to give the time we reserved for you to another patient who may have been waiting for an appointment. Missed or broken appointments without adequate notice will be charged to the patient's account. The missed or broken appointment fee is \$50.00

***Print Name _____

Patient Signature _____

Or

Parent or Guardian (for minor child) _____

Date: _____