Simply Smiles Dentistry

Patient Information			Date:			
Name:			Date of Birth	:/_	/	Phone Number:
Last Name,			rst Name			Cell Number:
SSN:			How did you hear abou	ut our o	ffice?_	
Street Address:				Apt #		
City:			ate:	Zip C	ode:	
Email:			rson tto contact in case of an l	Emerge	ncy:	 Phn #:
Insurance :			Phone Numb	er:		
			Group Name: (Employer)			
Primary Member Date of B						
Primary Dental Insurance:						
Member ID Number:				ocurance	٥.	
MEDICAL HISTORY			Secondary Insurance:			
	e care o	of a nhvs	sician? YES NO If YES, fo	or what?	•	
Please tell us the name of						Phone #:
Please List any allergies:	your pri	illiary oc	care priye orani.			Latex Allergy: Yes No
Do vou smoke or use toba	acco? YE	S NO	If YES, how much?	ŀ	lave voi	u had drug/alcohol addiction? YES NO
						Taking oral contraceptives? YES NO
Tor Worneri. Are you preg	griant or	trying to	Conceive: 123 NO Nuis	sing: 11	LO NO	Taking trait contraceptives: TES INO
Please	Circle	EACH	I ITEM If You <i>HAVE</i> OR	HAVE	E HAD	Any of the following:
Artificial Joints/Bones	YES	NO	Yellow Jaundice	YES	NO	Do you have any diseases, condition or
Hypoglycemia	YES	NO	Kidney Problems	YES	NO	not listed above that we should know about"
Liver Disease	YES	NO	Renal Disease	YES	NO	
Hepatitis A B C Other	YES	NO	Thyroid Problems	YES	NO	
Stroke	YES	NO	Rheumatism	YES	NO	
Heart Disease/Surgery	YES	NO	Cortisone Medication	YES	NO	Diagon list any and all modifications that
Heart Murmur/Defect Irregular Heart Beat	YES YES	NO NO	Lung Disease Breathing Problem	YES YES	NO NO	Please list any and all mediations that you are taking:
Angina / Chest Pain	YES	NO	Frequent Cough	YES	NO	you are taking
Heart Attack/Failure	YES	NO	Sinus Trouble	YES	NO	
Congenital Heart Disorder	YES	NO	Asthma	YES	NO	
Mitral Valve Prolapse	YES	NO	Herpes	YES	NO	Here were even been told to were allege
Scarlet Fever	YES	NO	Emphysema	YES	NO	Have you ever been told to premedicate
Rheumatic Fever Artificial Heart Valve	YES YES	NO NO	Tuberculosis Cancer	YES YES	NO NO	Before a dental procedure: If yes, why?
Heart Pace Maker	YES	NO	Radiation Treatment	YES	NO	ii yes, wiiy:
Pulmonary Shunt	YES	NO	Chemotherapy	YES	NO	
Coronary Stent	YES	NO	Osteoporosis	YES	NO	
High Blood Pressure	YES	NO	Bisphosphonates	YES	NO	Any Changes to your Medical History:
Low Blood Pressure Bacterial Endocarditis	YES	NO	Osteonecrosis of Jaw	YES	NO	Madical Livilladata
Bruise Easily/Blood Disease	YES YES	NO NO	Aredia IV Reclast IV Zometa IV	YES YES	NO NO	Medical Hx Update: Date:
Anemia	YES	NO	Fosamax, Actonel, Boniva	YES	NO	Reviewing Dr:
Excessive Bleeding	YES	NO	Ulcers	YES	NO	
Sickle Cell Disease	YES	NO	Recent Weight Loss/Gain	YES	NO	Medical Hx Update:
Hemophelia Leukemia	YES YES	NO NO	Diabetes Tumors/Growths	YES YES	NO NO	Date:Reviewing Dr:
Blood Transfusion	YES	NO	HIV Positive/AIDS	YES	NO	Reviewing Bi
Alzheimer's/Dementia	YES	NO	Glaucoma	YES	NO	Medical Hx Update:
Cold Sores/Fever Blisters	YES	NO	Epilepsy/Seizures	YES	NO	Date:
Psychiatric Care	YES	NO				Reviewing Dr:
My signature below acknowle	edges tha	t all the p	preceding answers are correct. If	I have ch	anges in	my health or medications, I will inform the staff.
Patient / Guardian Signature: Date:						
Signature of Review	ing De	octor:				Date
Signature of Iveriew	y D	,5101.				Date: