Smith Family Dentistry
Medical/Personal History

Name _____ Address _____
City_____ State _____ Zip _____ Home Phone_____
Work Phone _____ Sex (M/F)_____ Marital Status_____ Age_____
Birth Date_____ Social Sec. # _____ Driver's License # _____
Name of Responsible party _____
Billing Address _____ Insurance - Yes/No _____
Employer Name _____
Address _____ City _____ State _____ Zip _____
Insurance Company Name_____ ID # _____
Referred By _____
In Case of Emergency, Notify _____ Phone # _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Heart Condition	Anemia or Hemophilia	Skin Rash or Hives	Cortisone Medicine
Heart Attack or Stroke	Bruise Easily	Kidney Trouble	Glaucoma
Heart Murmur	Shortness of Breath	Diabetes	Arthritis
Chest Pains (Angina)	Swelling of Ankles	Sickle Cell Disease	Pain in Jaw Joints
Heart Surgery	Artificial Joint	Liver Disease	Artificial Heart Valve
Fainting or Dizzy Spells	Lung Disease	Hepatitis	Alcoholism
Heart Pacemaker	Emphysema	Sinus Trouble	Drug Addiction
High Blood Pressure	Tuberculosis (T.B.)	Blood Transfusion	Cancer or Tumor
Rheumatic Fever	Asthma or Hay Fever	Thyroid Disease	Radiation Therapy
Chemotherapy	HIV Positive/AIDS	Venereal Disease	Genital Herpes
Cold Sores	Epilepsy	Seizures	Psychiatric Treatment

If you circled any conditions, diseases, or problems above please explain. _____
_____
_____
_____

Do you have any conditions, diseases, or problems not listed above? If yes, please explain._____
_____
_____
_____

Are you presently taking any medicine, drug, or substance? Yes/No If Yes, please list drug, dose, and frequency.
_____
_____
_____
_____

Are you taking any medications for osteoporosis? Do you take any bisphosphonates drugs such as AREDA, RECLAST, ZOMETA, FOSAMAX, ACTONEL, or BONIVA? If yes, please list. _____

_____

Are you allergic to any medication, drug, or substance? Yes/No If Yes, please list: _____

_____

Have you ever taken Fen-Phen or Redux?..... Yes/No
Are you now, or have you been under the care of a medical doctor
during the last two years?..... Yes/No
Have you ever been hospitalized or had surgery?..... Yes/No
Have you ever had a reaction to local anesthetic? ..... Yes/No
Have you ever had prolonged or unusual bleeding? ..... Yes/No
Have you ever had complications or illness following dental treatment?..... Yes/No
Have you ever had an injury to your face or jaw? ..... Yes/No
Do you hear clicking, popping, or grating sounds in your jaw joints?.....Yes/No
Have you ever been required to take antibiotics before visiting the dentist?.....Yes/No
Would you be interested in having straighter teeth?.....Yes/No
Do you smoke or use smokeless tobacco? ..... Yes/No
Are you nervous or concerned about having dental work done? ..... Yes/No
Are you having any pain or discomfort at this time? ..... Yes/No
What is your present health? Good _____ Fair _____ Poor_____

Women:
Are you pregnant? Due Date_____ ..... Yes/No
Are you taking birth control pills? ..... Yes/No
Do you anticipate becoming pregnant?..... Yes/No

Dental treatment desired. (Circle)

Check up	Replacing Missing Teeth	Cavities Restored	Cleaning
Cosmetic Bonding	Teeth Extracted	Complete Dentures	Orthodontics

Other _____

Best time for dental appointments: Can arrange anytime [ ]

Mon.	AM	Tues.	AM	Wed.	AM	Thurs.	AM	Fri.	AM
	PM		PM		PM		PM		PM

Date_____ Signature of Patient, Parent, or Guardian_____

Doctor's Notes:

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