

Pt Name: \_\_\_\_\_ Preferred name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_

Physician's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you allergic to any of the following?  Penicillin  Codeine  Aspirin  Latex  Metals  Sulfa Drugs  
 Local Anesthetics  Other \_\_\_\_\_  I have no known allergies

Are you taking any medication by mouth at the present time? Please list name and reason, including over the counter drugs, vitamins or herbal remedies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate if you **have or ever had** any of the following medical conditions? (if yes, please explain)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal, excessive bleeding  | <input type="checkbox"/> Diabetes (type I or II)   | <input type="checkbox"/> HIV positive, AIDS         |
| <input type="checkbox"/> ADD / ADHD                    | <input type="checkbox"/> Epilepsy / Seizures       | <input type="checkbox"/> Jaundice                   |
| <input type="checkbox"/> Alcoholism / Drug addiction   | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Kidney / Liver Disease     |
| <input type="checkbox"/> Allergies (hay fever)         | <input type="checkbox"/> Handicaps / Disabilities  | <input type="checkbox"/> Mitral valve prolapse      |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Hearing problems          | <input type="checkbox"/> Radiation treatment        |
| <input type="checkbox"/> Any Surgery / Hospitalization | <input type="checkbox"/> Heart Disease / Attack    | <input type="checkbox"/> Respiratory problems       |
| <input type="checkbox"/> Any type of transplant        | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Heart Pacemaker           | <input type="checkbox"/> Sinus Problems             |
| <input type="checkbox"/> Artificial heart valve        | <input type="checkbox"/> Heart Surgery             | <input type="checkbox"/> Smoker / Chewing tobacco   |
| <input type="checkbox"/> Artificial hip / knee         | <input type="checkbox"/> Hemophilia                | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Hepatitis Type: _____     | <input type="checkbox"/> Thyroid problems           |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Herpes or cold sores      | <input type="checkbox"/> Tonsils / Adenoids removed |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Tuberculosis (TB)          |

Does your physician recommend antibiotics prior to dental visits?  Y  N  I am not sure

**For women only:** Are you pregnant?  Y  N • Are you nursing?  Y  N • Are you taking birth control pills?  Y  N

Date of last dental visit: \_\_\_\_\_ Reason for **last** dental visit: \_\_\_\_\_

What is the reason for your visit **today**?  Evaluation / Cleaning  Toothache  Cosmetic Evaluation  
 Broken Tooth  Snoring Device Evaluation  Other \_\_\_\_\_

- Do your gums bleed?  Yes  No • Do you feel you have bad breath?  Yes  No  
 Have you ever needed a periodontal (deep) cleaning in the past?  Yes  No  
 Have you ever felt like you clench or grind your teeth?  Yes  No  
 Have you ever felt any lumps or bumps in your mouth?  Yes  No  
 Have you ever been interested in a whiter smile?  Yes  No  
 Have you ever thought about straightening out your teeth?  Yes  No  
 Are you interested in replacing your silver mercury fillings with white restorations?  Yes  No

Is there anything that might make you uncomfortable during your visit? (for example cold water or mint toothpaste)  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything we can do to make your visit more comfortable? \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical history. All information will be held in the strictest confidence. I authorize Just Smiles to perform the necessary dental services I will need.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date