HENZEL SMITH
General Dentistry

PATIENT INFORMATION

PATIENT NAME____________________ MALE_____ FEMALE_____ DATE____________________
HOME ADDRESS____________________ BIRTHDATE____________________ SOCIAL SECURITY#____________________
____________________ EMAIL____________________
MINOR___ SINGLE___ MARRIED___ DIVORCED___ WIDOWED___ HOME PHONE____________________ CELL PHONE____________________
EMPLOYER____________________ WORK PHONE____________________
EMERGENCY CONTACT____________________ EMERGENCY CONTACT PHONE____________________
REFERRED BY____________________ DENTAL INSURANCE SUBSCRIBER NAME____________________
SUBSCRIBER EMPLOYER____________________ ID#____________________ SS#____________________ BIRTHDATE____________________
GROUP #____________________ ADDRESS____________________ INS PHONE#____________________

PATIENT MEDICAL HISTORY

PHYSICIAN____________________ OFFICE PHONE____________________ LAST COMPLETE PHYSICAL____________________

YES NO

____ ____ ARE YOU UNDER MEDICAL TREATMENT NOW? ____________________
____ ____ HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS? ____________________
____ ____ ARE YOU TAKING ANY MEDICATIONS INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT? ____________________
____
____ ____ DO YOU USE TOBACCO? ____________________
____ ____ DO YOU TAKE PREMEDICATION FOR DENTAL APPOINMTMENTS? IF YES, PLEASE SPECITFY____________________
____ ____ ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY____________________
____

WOMEN ONLY: ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? __________ ARE YOU NURSING? ____________________

PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. PLEASE CHECK ONLY IF ANSWER IS YES.

___ HIGH BLOOD PRESSURE	___ STOMACH TROUBLES/ULCERS	___ FREQUENTLY TIRED	___KIDNEY DISEASES	___ LIVER DISEASE
___ CARDIAC PACEMAKER	___ ACID REFLUX	___BONE DENSITY DRUGS	___ THYROID PROBLEMS	___ HEPATITIS/JAUNDICE
___ LOW BLOOD PRESSURE	___ BLOOD THINNERS	___ CANCER	___ DIABETES	___ AIDS/HIV/STD INFECTION
___ HEART MURMUR	___ RESPIRATORY PROBLEMS	___FAINTING/SEIZURES	___ LEUKEMIA	___ EPILEPSY/CONVULSIONS
___ ARTIFICIAL HEART VALVE	___ EMPHYSEMA	___ARTHRITIS	___STROKE	___SNORING/SLEEP APNEA
___ CHEST PAINS	___ TUBERCULOSIS	___GLAUCOMA	___ RHEUMATIC FEVER	___ JOINT REPLACEMENT OR IMPLANT
___ HEART ATTACK	___ ASTHMA	___ ALLERGIES/SPECIFY ____________	OTHER ____________	
___ ARTIFICIAL HEART VALVE				

PATIENT DENTAL INFORMATION

WHAT IS THE REASON FOR YOUR VISIT TODAY? ____________________
HAVE YOU HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? EXPLAIN____________________
HOW DO YOU FEEL ABOUT YOUR SMILE? ____________________
WHAT WOULD YOU LIKE TO CHANGE IF YOU COULD? ____________________

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient/Legal Guardian: ____________________ Date:____________________