HENZEL SMITH

General Dentistry

PATIENT INFORMATION

PATIENT NAME_____MALE_____FEMALE_____DATE_____

HOME ADDRESS_____ BIRTHDATE_____SOCIAL SECURITY#_____

_____EMAIL_____

MINOR_____ SINGLE_____ MARRIED_____ OTHER_____ HOME PHONE_____ CELL PHONE_____

EMPLOYER_____ WORK PHONE_____

EMERGENCY CONTACT_____EMERGENCY CONTACT PHONE_____

DENTAL INSURANCE_____SUBSCRIBER NAME_____

SUBSCRIBER EMPLOYER_____ID#_____SS#_____BIRTHDATE_____

GROUP #_____ADDRESS_____INS

PHONE#_____REFERRED BY _____

PATIENT MEDICAL HISTORY

PHYSICIAN_____OFFICE PHONE_____LAST COMPLETE PHYSICAL_____

YES NO

_____ _____ ARE YOU UNDER MEDICAL TREATMENT NOW? _____

_____ _____ HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS WITHIN THE LAST YEAR?_____

_____ _____ 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 SPECIFY_____

_____ _____ DO YOU HAVE ANY KNOWN DRUG ALLERGIES OR OTHER ALLERGIES? IF YES, PLEASE SPECIFY_____

_____

PLEASE CHECK MARK ANY OF THESE CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

____ HIGH BLOOD PRESSURE	____ STOMACH TROUBLES/ULCERS	____ FREQUENTLY TIRED	____KIDNEY DISEASES	____ LIVER DISEASE
____ CARDIAC PACEMAKER	____ ACID REFLUX	____BONE DENSITY DRUGS	____ THYROID PROBLEMS	____ HEPATITIS/JAUNDICE Type _____
____ 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			OTHER _____

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

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:_____