# Simply Smiles Dentistry

Date:_______________

## Patient Information

Name: ________________________________________ Date of Birth:____/_____/____ Home:__________________________

Last Name, First Name

Cell:______________________________

SSN:_______-______-________ **How did you hear about our office?**____________________________________

Street Address: __________________________________________ Apt # __________________

City:_________________________ State:_____________ Zip Code: ______________

Email:________________________________ Emergency Contact:_________________________ Phone:___________________

**Insurance :**

Insurance Phone Number:____________________________

Primary Insured Name:__________________ _________ Group Name: (Employer)____________________________

Primary Member Date of Birth:_____________________ Group Number:____________________________________

Primary Dental Insurance Name:__________________________________________

Member ID Number:______________________________ Secondary Insurance:______________________________

## MEDICAL HISTORY

Are you currently under the care of a physician? YES NO If YES, for what? ______________________________

Please tell us the name of your primary care physician: __________________________ Phone #: ______________

Please List any allergies: ________________________________________ **Latex Allergy: Yes No**

Do you smoke or use tobacco? YES NO If YES, how much? ________ Have you had drug/alcohol addiction? YES NO

*For Women:* Are you pregnant or trying to conceive? YES NO Nursing? YES NO Taking oral contraceptives? YES NO

### Please Circle EACH ITEM If You *HAVE* or NOT *HAD* Any of the following:

| Condition | | | Condition | | |
|---|---|---|---|---|---|
| **Artificial Joints/Bones** | YES | NO | Yellow Jaundice | YES | NO |
| Hypoglycemia | YES | NO | Kidney Problems | YES | NO |
| 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 |
| Heart Murmur/Defect | YES | NO | Lung Disease | YES | NO |
| Irregular Heart Beat | YES | NO | Breathing Problem | YES | NO |
| Angina / Chest Pain | YES | NO | Frequent Cough | YES | NO |
| 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 |
| Scarlet Fever | YES | NO | Emphysema | YES | NO |
| Rheumatic Fever | YES | NO | Tuberculosis | YES | NO |
| **Artificial Heart Valve** | YES | NO | Cancer | YES | NO |
| Heart Pace Maker | YES | NO | Radiation Treatment | YES | NO |
| Pulmonary Shunt | YES | NO | Chemotherapy | YES | NO |
| Coronary Stent | YES | NO | Osteoporosis | YES | NO |
| High Blood Pressure | YES | NO | Bisphosphonates | YES | NO |
| Low Blood Pressure | YES | NO | Osteonecrosis of Jaw | YES | NO |
| Bacterial Endocarditis | YES | NO | Aredia IV Reclast IV | YES | NO |
| Bruise Easily/Blood Disease | YES | NO | Zometa IV | YES | NO |
| Anemia | YES | NO | **Fosamax, Actonel, Boniva** | YES | NO |
| Excessive Bleeding | YES | NO | Ulcers | YES | NO |
| Sickle Cell Disease | YES | NO | Recent Weight Loss/Gain | YES | NO |
| Hemophelia | YES | NO | **Diabetes** | YES | NO |
| Leukemia | YES | NO | Tumors/Growths | YES | NO |
| Blood Transfusion | YES | NO | HIV Positive/AIDS | YES | NO |
| Alzheimer's/Dementia | YES | NO | Glaucoma | YES | NO |
| Cold Sores/Fever Blisters | YES | NO | Epilepsy/Seizures | YES | NO |
| Psychiatric Care | YES | NO | | | |

**Do you have any diseases, condition or not listed above that we should know about"** ______________________________
______________________________________
______________________________________
______________________________________

Please list any and all medications you are taking:__________________ __________
______________________________________
______________________________________
______________________________________

Have you ever been told to **premedicate** with an antibiotic before a dental procedure? ____________________ __________

If yes, why? ________________

**Any Changes to your Medical History:**

Medical Hx Update:_______________________
Date:_________________________ __________
Reviewing Dr:__________________________

Medical Hx Update:_______________________
Date:_________________________ __________
Reviewing Dr:__________________________

Medical Hx Update:_______________________
Date:_________________________ __________
Reviewing Dr:__________________________

**I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information**

**Patient / Guardian Signature:** ______________________________ **Date:** ________________

**Signature of Reviewing Doctor:** ______________________________ **Date:** ________________