Smile Center

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Accurate reporting of your medical history is important as it may affect treatment decisions. The information is confidential and will be handled in accordance with our privacy policy which is available upon request.

Last Name: First Name:

Date of Birth: Gender: Social Security Number:

Home Address:

Phone number: Email:

No	Yes		List Medications:
☐	☐	Do you require antibiotics before dental treatment?	
☐	☐	Have you had any abnormal reactions to anesthesia?	
☐	☐	Do you use tobacco (smoke, vape, dip)	
☐	☐	Are you pregnant? *(Females only)*	
☐	☐	Are you currently taking medications?	
☐	☐	Have you ever had bleeding issues after dental treatment?	

List any drugs allergies:

List any other allergies:

Date of last physical exam:

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?
Please check if you have a history of any of the following

☐ Heart attack	☐ Kidney disease	☐ Digestive conditions
☐ Angina/ Chest pain	☐ TMJ Pain	☐ Hepatitis / liver diseases
☐ High blood pressure	☐ Snoring/ Sleep Apnea	☐ Diabetes
☐ Cardiac Pacemaker	☐ Cancer	☐ Asthma
☐ Epilepsy/ Seizures	☐ Heartburn	☐ Bronchitis / emphysema
☐ Migraines	☐ Glaucoma	☐ COPD
☐ Thyroid Disease	☐ Prosthetic joint	☐ Anemia
☐ Anxiety/Depression	☐ Radiation therapy	☐ Leukemia
☐ Stroke	☐ Osteoporosis	☐ Bleeding disorders

List any other conditions: _____

Patient/Guardian Signature _____ **Date** _____

Office Use Only:

Reviewed by: _____ **Date** _____

Insurance Information:

Primary Insurance:

Insurance Company: _____

Insurance Company Phone Number: _____

Group Number: _____

Policy Owner Name: _____

Policy Owner Birthdate: _____

Policy Owner Social Security Number: _____

Policy Owner Employer: _____

Secondary Insurance:

Insurance Company: _____

Insurance Company Phone Number: _____

Group Number: _____

Policy Owner Name: _____

Policy Owner Birthdate: _____

Policy Owner Social Security Number: _____

Policy Owner Employer: _____

FOR MINORS ONLY:

Who can provide legal consent for treatment: _____

_____

Who will be financially responsible for treatment: _____

_____

Who can bring/pick up you child for appointments: _____

_____

_____

Name and Relationship to Patient

_____

Signature Date