Patient's Health Information

Patients Name_____ Date of Birth_____

Patients Social Security or Medi-Cal ID number_____
Address/Facility Address_____
Facility Name_____
Facility Contact_____
Phone_____Email_____

Dental History

Reason for today's visit_____
Name of Dentist_____Phone_____
Date of last dental care_____
Circle if you have problems with any of the following:

Bad breath or taste	Bleeding gums	Sores or growths in your mouth
Food collection between teeth	Your partial or denture	Loose teeth
Broken fillings	Dry mouth	Sensitivity to hot/cold/biting

Medical History

Name of Physician_____Address_____
Phone_____Fax_____
Antibiotic Premedication need for dental treatment in the past? Yes_____ No_____ Unknown_____

Circle if you have any of the following:

Anemia	Cortisone Treatments	Hemophilia	Rheumatic Fever
Arthtritis, Rheumatism	Cough, Persistent	Hepatitis	Shortness of Breath
Artificial Heart Valve	Cough up Blood	HIV/AIDS	Stroke
Artificial Joints	Diabetes	Jaw Pain	Swelling of Feet or Ankles
Asthma	Epilepsy/Seizures	Kidney Disease	Thyroid Problems
Back Problems	Fainting	Liver Disease	Dementia
Blood Disease	Glaucoma	Mitral Valve Prolapse	Blindness
Cancer	Headaches	Pacemaker/Difibulator	Deaf
Chemotherapy	Heart Murmur	Radiation Treatment	Parkinson's Disease
Circulatory Problems	Heart Problems	Respiratory Disease	Alzheimer's Disease

Specify any Allergies_____
List Medications_____
_____
_____
Pharmacy Name_____Phone_____

The above information is accurate and complete to the best of my knowledge. I will not hold Smiles By Staci or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Signature_____Date_____
Printed Name_____Relationship to Patient_____

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