Welcome to

Smile Shapers

Family and Cosmetic Dentistry

Adult Medical History

PATIENT INFORMATION

Name: *(Last, First, M.I.)* DOB: ☐ Male ☐ Female

Home Address: Home Phone: ( )

City/State/Zip How long at this address?

Driver's License No.: Soc. Sec. No.: Cell Phone: ( )

Employer: Occupation: Work Phone: ( )

Who may we thank for referring you to our office?

Date of last dental visit: Email:

Primary reason for this visit?

Spouse/Responsible Party: *(Last, First, M.I.)* DOB: ☐ Male ☐ Female

Home Address: *(If different from patient)* Home Phone: ( )

City/State/Zip How long at this address?

Driver's License No.: Soc. Sec. No.: Cell Phone: ( )

Employer: Occupation: Work Phone: ( )

EMERGENCY CONTACT INFORMATION

Primary Contact:		Secondary Contact:	
Relationship:		Relationship:	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

DENTAL INSURANCE INFORMATION

PRIMARY		SECONDARY	
Insured's Name:		Insured's Name:	
Date of Birth:	SSN:	Date of Birth:	SSN:
Employer:		Employer:	
Relationship to subscriber:		Relationship to subscriber:	
Insurance Company:		Insurance Company:	

MEDICAL INFORMATION

Physician Name: Phone: ( ) Fax: ( )

Physician Address: Date of Last Exam:

DOCTOR UPDATES

DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X

Continued on reverse. Please complete both sides.

MEDICAL HISTORY

Certain illnesses and drugs may have a direct effect on the oral cavity and, consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary that **Smile Shapers** has the following information.

Please check [✓] if you have or have had problems with any of the following:

☐ AIDS/HIV Positive	☐ Claustrophobia	☐ Hemophilia	☐ Rheumatic Fever
☐ Allergies	☐ Congenital Heart Disease	☐ Hepatitis Type _____	☐ Scarlet Fever
☐ Anemia	☐ Contact Lenses	☐ Herpes	☐ Shortness of Breath
☐ Angina	☐ COPD	☐ High Blood Pressure	☐ Seizures
☐ Anxiety	☐ Cortisone Treatments	☐ Jaundice	☐ Sinus Trouble
☐ Arthritis, Rheumatism	☐ Cough, persistent or bloody	☐ Jaw Pain	☐ Skin Rash
☐ Artificial Heart Valves		☐ Kidney Disease	☐ Special Diet
☐ Artificial Joints	☐ Diabetes	☐ Leukemia	☐ Stroke
☐ Asthma or Hay Fever	☐ Emphysema	☐ Liver Disease	☐ Swollen Feet or Ankles
☐ Back Problems	☐ Endocarditis	☐ Low Blood Pressure	☐ Swollen Neck Glands
☐ Bleeding abnormally, with extractions or surgery	☐ Epilepsy	☐ Measles or Mumps	☐ Thyroid Problems
	☐ Fainting or dizziness	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Blood Disease	☐ Fibromyalgia	☐ Nasal Obstruction	☐ Tuberculosis
☐ Blood Transfusion	☐ Glaucoma	☐ Neurological Problems	☐ Tumor or growth on head or neck
☐ Cancer Therapy	☐ Headaches	☐ Pacemaker	
☐ Chemical Dependency	☐ Heart Attack	☐ Psychiatric Care	☐ Ulcer
☐ Chemotherapy	☐ Heart Murmur	☐ Radiation Treatment	☐ Venereal Disease
☐ Circulatory Problems	☐ Heart Disease	☐ Respiratory Disease	☐ Weight Loss, unexplained

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs.

Check [✓] the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

☐ Anesthetics, Locally Injected	☐ Fen-phen (Ionimin, adipex, Fastin, phentermine, Pondimin, fenfluramine, Redux, dexfenfluramine)
☐ Anesthetics, General	
☐ Antacids	☐ Heart Medications such as Digoxin, Nitroglycerin or Digitalis
☐ Anti-anxiety Medications	
☐ Anti-depressants	☐ Ibuprofen (Motrin)
☐ Antihistamines	☐ Insulin or Diabetes Medications
☐ Daily Aspirin Regimen	☐ Sedatives or Tranquilizers
☐ Birth Control Pills	☐ Sleeping Pills (Barbiturates)
☐ Blood Pressure Medications	☐ Thyroid Medication such as Synthroid, Levoxyl or Levothyroxine
☐ Codeine, Demerol or Other Analgesics	
☐ Cortisone or Other Steroids	☐ Tylenol (Acetaminophen)
☐ Coumadin, Heparin, Warfarin or other blood thinners	☐ Adverse reaction to any other medication or drug? Please specify:
☐ Dilantin	
☐ Diuretics (water pills)	

Check [✓] current uses/conditions:

	YES	NO
1. Tobacco . . . . (Packs per day:_______)	☐	☐
2. Alcohol, Beer, Wine . . . . (Drinks per day:_______)	☐	☐
3. Street Drugs . . . . (Times per day:_______)	☐	☐
4. Caffeine . . . . (Cups per day:_______)	☐	☐
5. High Stress . . . . (Reason:_________________)	☐	☐
6. Serious illnesses or surgeries . . *Please describe:*_______________	☐	☐
7. Women: Pregnant?	☐	☐
8. Women: Nursing?	☐	☐
9. Are there any other health problems not listed . . . . *Please describe:*_______________	☐	☐

Please list all medications you are currently taking:

_______________ _______________ _______________

_______________ _______________ _______________

PATIENT SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

I hereby certify that the information provided on this form is true and correct in its entirety. By signing this form, I acknowledge my responsibility for any professional fees incurred for dental services provided.

I authorize **Smile Shapers** to release my dental records to the insurance carrier(s) named on the reverse side for insurance purposes.

Signed X **Date**