# smiles

## ON STATE STREET

**Patient Name: _____ Date of Birth _____**

So that we can better assist you with your dental concerns, please list in order of importance what is essential to you.

___Health preservation/keeping your teeth for life, eliminate disease
___Comfort and function/eating what you want to eat
___Esthetics/how your smile looks

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling?
**Please mark 1—3, with 1 being most important item.**

___Cost
___Fear of pain
___No time
___No insurance
___Didn't hurt/ Didn't think I needed treatment
___Other (please explain)_____

## HEALTH HISTORY

Check if you have or had any of the following:

___AIDS
___Anemia
___Arthritis
___Artificial Heart Valve
___Artifical Joints
___Asthma
___Back Problems
___Cancer, Tumor, Malignancy
___Chemical Dependency
___Chemotherapy
___Circulatory Problems
___Cortisone Treatments
___Cough up blood
___Congenital Heart Disorder
___Cough, Persistant
___Diabetes
___Epilepsy, Seizures
___Fainting, Dizziness
___Glaucoma
___Headaches
___Heart Attack
___Heart Murmur
___Hepatitis, Type ____
___Herpes
___High Blood Pressure
___HIB Positive
___Hospitalization
___Immune Disorder
___Jaundice
___Kidney Disease
___Liver Disease
___Major Surgery, Type _____
___Mitral Valve Prolapse
___Nervous Problems
___Pacemaker
___Pain in Jaw Joint
___Prolonged Bleeding Disorder
___Psychiatric Care
___Radiation Treatment
___Respiratory Disease
___Rheumatic Fever
___Scarlet Fever
___Shortness of breath
___Sinus Trouble
___Skin Rash
___Stroke
___Swelling of Feet or Ankles
___Taking Fen-Phen or Redux
___Thyroid Problems
___Tobacco Habit, Type _____How much _____
___Tonsilitis
___Lung Disease
___Tuberculosis
___Ulcer
___Venereal Disease
___Are you Pregnant? Due Date _____

**Medications**

List medications you are currently taking:
(Include oral contraceptives and alternative medicines)

_____
_____
_____
_____

**Allergies**

___Local Anesthetic
___Latex
___Metal
___Aspirin
___Penicillin
___Other
___Sulfa
___Codeine

**Have you taken Bisphosphate for bone density, such as: Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Reclast, Zometa? _____**

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

Signature _____ Date_____