NAMPA SMILES Sedation & Family Dentistry

Patient Name: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Perferred Method of Contact: (Circle) TEXT EMAIL CALL

Gender: M F Marital Status: _____ Birthdate: ____/_____/_____ SSN: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referral Source: How did you hear about our office? _____

Name of Insurance: _____ Ins. ID #: _____

Subscriber Name: _____ Subscriber DOB: _____

Health Information *(Please circle all those that apply past and/or present)*

AIDS/HIV positive
Alzheimers
Anemia
Arthritis
Artificial Joints:
Date: _____
Artificial Heart Valve
Asthma
Blood Disease
Blood Thinners
Blood Transfusuion
Cancer
Diabetes - I or II
Dizziness
Drug Abuse
Endocarditis
Epilepsy
Epinephrine Reaction
Excessive Bleeding
Glaucoma: open/close
Head Injuries
Heart Attack/Disease
Date: _____
Heart Murmur
Hepatitis A B C
High Blood Pressure
Hypoglycemic
Kidney Disease
Liver Disease
Nervous Disorder
Osteoporosis Meds
Pacemaker
Pregnant? Due: _____
Radiation Treatment
Respiratory Problem
Rheumatic Fever
Sinus Problems
Stroke date: _____
Thyroid Disorder
Tuberculosis
Tumors

Tobacco use frequency:_____

Allergies:

☐ Latex ☐ Other:
☐ Metal _____
☐ Penicillin _____
☐ Codeine _____

Drug Allergies: Please list below

_____
_____
_____
_____
_____

Initial here if you have none of the above: _____

If you have any other health concerns, please explain:

_____ _____
_____

Please list medications you are currently taking:

_____
_____
_____
_____

Do you need to take antiobiotics before cleanings?

YES NO

If yes, which one? _____

How do you rate your level of fear of dental treatment: _____ **Excessive** _____ **Moderate** _____ **Low**

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change of health I will inform the doctor at my next appointment.

_____ _____
Signature of patient, parent, or guardian. Date

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Yearly Health Update: (Please initial and add today's date) _____ _____ _____ _____