NAMPA SMILES Sedation & Family Dentistry

Name: _____ Email: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Phone Number: _____ Work Number: _____

**Perferred Method of contact :** (Circle) Text Email Phone SSN: _____

Gender: M F Marital Status: _____ Birthdate: _____

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 1 or 2
Dizziness
Drug Abuse
Endocarditis
Epilepsy
Epinephrine Reaction
Excessive Bleeding
Glaucome: 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
- ☐ Metal
- ☐ Penicillin
- ☐ Codeine
- ☐ Others

**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 Medication you are currently taking:**

_____
_____
_____
_____

Do you need to take antiobiotics before cleaning:
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:

**********

**Yearly Health Update**: (Please initial and add todays date)_____ _____ _____

***Patient Name*_____**

***Nampa Smiles Family Dentistry has my permission to discuss my:***

Health Record, Insurance, and Ledger Information with the following:

_____D.O.B._____ Relationship_____

_____D.O.B._____Relationship_____

_____D.O.B._____Relationship_____

_____ _____

Signed Dated