Great Smiles Dental S.C.

MEDICAL HISTORY

Patient Name: ______________________________ Birth Date: ____________________

Nickname: ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Thank you for answering the following questions.

Question	Answer	
Do you require ANTIBIOTICS before any dental work?	❍ Yes ❍ No	If yes, please explain: ______
Are you taking any BLOOD THINNERS?	❍ Yes ❍ No	If yes, please explain: ______
Are you under a physician's care now?	❍ Yes ❍ No	If yes, please explain: ______
Have you been hospitalized or had any major operations?	❍ Yes ❍ No	If yes, please explain: ______
Have you ever had a serious head or neck injury?	❍ Yes ❍ No	If yes, please explain: ______
Are you taking any medications? IF YES, PLEASE LIST	❍ Yes ❍ No	______
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	❍ Yes ❍ No	If yes, please explain: ______
Do you use tobacco or controlled substances?	❍ Yes ❍ No	If yes, please explain: ______
WOMEN: Pregnant?	❍ Yes ❍ No	

Are you allergic to any of the following?

Aspirin	❍ Yes ❍ No	Penicillin/Amoxicillin	❍ Yes ❍ No	Codeine	❍ Yes ❍ No	Metal	❍ Yes ❍ No
Latex	❍ Yes ❍ No	Sulfa Drugs	❍ Yes ❍ No	Local Anesthetics	❍ Yes ❍ No	NSAIDS	❍ Yes ❍ No

Do you have any other allergies that is not listed above? ❍ Yes ❍ No If yes, please explain: ______

Do you have, or have you had any of the following?

AIDS/HIV	❍ Yes ❍ No	Cancer	❍ Yes ❍ No	Heart Attack	❍ Yes ❍ No	Parathyroid Disease	❍ Yes ❍ No
Acid Reflux/GERD	❍ Yes ❍ No	Cerebral Palsy	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No
Alzheimer's Disease	❍ Yes ❍ No	Chemo/Radiation	❍ Yes ❍ No	Heart Pacemaker	❍ Yes ❍ No	Rheumatism	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Cold sore/Canker sores	❍ Yes ❍ No	Hepatitis A, B, or C	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Angina (Chest Pains)	❍ Yes ❍ No	Congenital Heart Failure	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Anxiety/Depression	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Sjogren's Syndrome	❍ Yes ❍ No
Arthritis	❍ Yes ❍ No	Dialysis	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No	Sleep Apnea	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Artificial Joint	❍ Yes ❍ No	Epilepsy/Seizures	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Swelling of the Limbs	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Excessive Bleeding	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No	Thyroid Disease	❍ Yes ❍ No
Autism	❍ Yes ❍ No	Fainting/Dizziness	❍ Yes ❍ No	Multiple Sclerosis	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Frequent Headaches	❍ Yes ❍ No	Osteoporosis	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: ______

Do you currently have any of the following?

Mouth Breathing/ Dry Mouth	❍ Yes ❍ No	TMJ/Clicking/ Popping/Pain	❍ Yes ❍ No	Grinding/Clenching	❍ Yes ❍ No	Sensitivity Hot, Cold, Sweet, Pressure (Circle all that apply.)	❍ Yes ❍ No
Broken Teeth	❍ Yes ❍ No	Bleeding/Swelling/ Irritation	❍ Yes ❍ No	Previous Periodontal/ Gum Disease	❍ Yes ❍ No		

Comments: ______________________________

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See back side. →

AUTHORIZATION FORM

Registration & Medical History Consent

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and is my responsibility to inform this office of any changes in my/my child's medical status. I authorize this dental staff to perform any necessary dental services that I /my child may need during diagnosis and treatment, with my informed consent.

***Patient Signature ______________________________

Or

Parent or Guardian (for minor child) ______________________________

Date: ______________

Financial Agreement

Payment is due in full at the time of treatment unless prior arrangements have been approved. This office accepts insurance. I understand that I am responsible for payment of services rendered and responsible for any amount my insurance does not cover.

I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Great Smiles Dental. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of all information necessary to secure the payment of benefits.

***Patient Signature ______________________________

Or

Parent or Guardian (for minor child) ______________________________

Date: ______________

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy/been offered a copy of this office's Notice of Privacy Practices.

***Patient Signature ______________________________

Or

Parent or Guardian (for minor child) ______________________________

Date: ______________

Media Essentials Consent--(***OPTIONAL***)

I give permission to Great Smiles Dental to use my name and photo in any and all publicity efforts. I understand that submission photos may be used in any publications including but not limited to print advertisements and online publications such as Facebook and the company web page. I also grant permission for Great Smiles Dental to recognize me as they desire for awards, accomplishments, and other notable events on their company Facebook page. By signing this agreement, I relinquish any monetary claims and agree to hold Great Smiles Dental harmless for any liability arising from participation. I state that I have no conflicts of interest with the subject matter and that I enter into this media agreement of my own free will.

***Patient Signature ______________________________

Or

Parent or Guardian (for minor child) ______________________________

Date: ______________