30-40-

ONE MILE SMILE

Date _____

Patient Name _____ **Birthdate** _____ **Age**____
First Middle Last

SS#_____DL#_____ **Occupation** _____Work # (____) _____

❑ Single ❑Married ❑Divorced ❑ Widowed ❑**Spouses Name**: _____ Work # (___) _____

Home Address_____**City**_____**State**_____ Zip _____

Home Number (____) _____ **Cell Phone** (___) _____

Fax # (___) _____ E- Mail Address _____

Employer Name and Address _____

Please fill out below if patient is under 18

Person Responsible for Account_____Relationship _____

Social Security # _____DL#_____Home # (___)_____

Home Address (if different**)**_____**City**_____ **State**_____**Zip**___

Employer & Address_____State_____Zip_____

Occupation_____Work # (___)_____

Do you have Dental Insurance? ❑Yes ❑No With Whom?

Nearest Relative Not Living With You?_____Relationship_____

Address_____City_____State_____Zip_____Phone_____

What are your concerns? *Mark all that apply:* ❑ Routine Checkup ❑ Cleaning ❑ Your General Health ❑ Appearance
❑ Pain Avoidance ❑ Cavities ❑ Losing Teeth ❑ Oral Cancer
❑ Gum/Periodontal Disease ❑ Wasting/Exceeding Dental Insurance Limits

Are you currently having a problem? _____

Medical

1. Have there been any changes in your health since your last visit? ❑ Yes ❑ No
   If yes explain: _____
2. Are you currently under the care of a physician? ❑ Yes ❑ No
   Physician's Name:_____ Reason:_____
3. Are you taking any medications? ❑ Yes ❑ No List:_____
4. **Are you allergic to any of the following:** ❑ **Penicillin** ❑ **Latex** ❑ **Sulfur** ❑ **Codeine**
   ❑ **Novocain** ❑ **Other:**_____

_____

5. Has your physician ever informed you that you have or had?

❑ **Congenital heart disease**	❑ **Rheumatic Fever**	❑ **Stroke**	❑ **Psychiatric Treatment**
❑ **Mitral Valve Prolapse**	❑ **Blood Disease**	❑ **Liver Disease**	❑ **Are You Pregnant**
❑ **High Blood Pressure**	❑ **Kidney Disease**	❑ **Diabetes**	❑ **Hepatitis**
❑ **Respiratory Disease**	❑ **Cancer**	❑ **Tuberculosis**	❑ **HIV+**
❑ **Stomach / Intestinal Disease**	❑ **Epilepsy / Convulsions**	❑ **Osteoporosis**	❑**Other**
❑ **Anemia / Leukemia / Low Platelets**	❑ **Abnormal Bleeding**	❑ **Asthma/Hay Fever**	
	❑ **Pacemaker**		

❑ **Organ / Valve / Joint / Replacement and/or Implant: Type:** _____

Doctor: _____ **Date:** _____

Initial

_____ **I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."**

Signature: _____ Date: _____