Smile Focus
DENTAL PRACTICE

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(661) 297-1523

Patient Information

First Name: _____ Last Name: _____ Birthdate: _____

☐ Female ☐ Male ☐ Prefer Not to State Social Security #: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

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

Email: _____ May We Contact You Via Email & Text? ☐ Yes ☐ No

Last Dental Visit: _____ Reason: _____

Emergency Contact Information

Name: _____ Relationship to Patient: _____ Phone #: (____) _____-_____

Health Information

AIDS/HIV	Y N	Epilepsy	Y N	Kidney Disease	Y N	Stroke	Y N
Anemia	Y N	Excessive Bleeding	Y N	Liver Disease	Y N	Taking Blood Thinners	Y N
Artificial Joints	Y N	Fainting	Y N	Mental Disorders	Y N	Thyroid Disorder	Y N
Asthma	Y N	Head Injuries	Y N	Pacemaker	Y N	Tuberculosis	Y N
Auto Immune Disorder	Y N	Heart Murmur	Y N	Respiratory Problems	Y N	Heart Disease	Y N
Cancer	Y N	Hepatitis	Y N	Sinus Problems	Y N	Other: _____	
Diabetes	Y N	High Blood Pressure	Y N	Stomach Problems	Y N	WOMEN: Currently Pregnant?	Y N
						Due Date: _____	

Any complications following dental treatment? ☐ Yes ☐ No If yes, please explain: _____

Have you been hospitalized during the past two years? ☐ Yes ☐ No If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No Do you need to pre-medicate? ☐ Yes ☐ No

Name of Physician: _____ Phone #: (_____) _____-_____

Have you ever taken the medication Fen-Phen? ☐ Yes ☐ No Bisphosphonates? ☐ Yes ☐ No

Other Medications: _____

Allergies: _____

Do your gums bleed when you brush and/or floss? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No If yes, how much do you smoke daily: _____

Do you have frequent headaches? ☐ Yes ☐ No

Do you clench/grind your teeth? ☐ Yes ☐ No Does your jaw get "stuck, locked or go out"? ☐ Yes ☐ No

What changes would you like to make to the appearance of your teeth? _____

To the best of my knowledge, all the of the answers and information provided are true and correct. If I ever have any changes in my health, I will inform Smile Focus at my next appointment.

Signature of Patient, Parent, or Guardian: _____ **Date:** _____