Salmon Creek Family DENTAL

Name _____ Date _____

Who may we thank for referring you? _____

Are you completely happy with the appearance of your smile? Yes No

Which of the following would you change if it could be done easily?

☐ Tooth color ☐ Spaces between teeth ☐ Size of teeth
☐ Tooth shape ☐ Alignment of teeth ☐ General overall smile

Are you aware of any allergies or adverse reactions to medications? Yes No

If yes, please list _____

Are you taking any medications, drugs or pills now? Please list _____

Have you ever had any of the following? Please check those that apply:

☐ **Allergies** _____
_____
☐ Anemia
☐ Arthritis
☐ Artificial Hip
☐ Artificial Knee
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis A, B or C
☐ High Blood Pressure
☐ HIV
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Osteoporosis (Thinning Bones)
☐ Pacemaker
☐ **Pregnant**
Due date: _____
☐ Radiation/Chemotherapy
☐ Respiratory Issues
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ Tuberculosis
☐ Thyroid Problems

OTHER

☐ _____
☐ _____

Have you had complications following dentistry? _____

Are you currently being treated by your physician for a medical condition? Yes No

Name of physician _____ Phone _____

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

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

FORM #161070