Clinton Smiles!

Health History

Name _____ Date _____

Date of birth: _____ Date of last dental visit if not here:_____

Have you ever had any of these? Please check all that apply:

____ Aids	_____ Hepatitis	____ Allergy to Nickel
_____ Anemia	_____ High Blood Pressure	____ Recent Surgeries
_____ Asthma	_____ Joint Replacement	____ Are you Pregnant
_____ Chemical Dependenc	_____ Pacemaker	____ If so, due date:
_____ Diabetes	_____ Radiation Treatment	_____
_____ Epilepsy	_____ Rheumatic Fever	
_____ Heart Disease	_____ Tuberculosis	____ None of these
_____ Heart Murmur	_____ Transplant/Prostheses	

Please list all medications including herbal supplements you are currently taking:
_____
_____
Please list any drug allergies you have: _____
_____
Have you ever had complications or allergic reactions following dental treatment? _____
If yes, please explain: _____

Do you prefer nitrous oxide (laughing gas) during dental procedures? _____

Do you use tobacc _____ If yes, for how long?_____

Are you interested in whitening your teeth? _____

Do you ever have a bad taste in your mouth? _____

(For people under the age of 18) Do you have/drink well water? _____

Name of Primary Physician_____
Do you have any health problems that need further clarification: _____
_____

I understand that photos may be taken and used for diagnostic and educational purposes _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have a change in my health I will inform the Doctor at the next appointment without fail.

Signature of Client, Parent or Guardian: _____ Date _____