!!! WELCOME !!!
Smile League Dental New Patient Form

Patient Information (CONFIDENTIAL)

Name_____ Birthdate_____ SS#_____

Address_____ City_____ Zip _____

Email_____ Cell Phone_____

Emergency Contact_____

Patient Medical History : Please Check All That Apply

High Blood Pressure___	Epilepsy/ Convulsions___	Cardiac Pacemaker___	Arthritis___
Heart Attack___	Leukemia___	Heart Murmur___	Chest Pains___
Rheumatic Fever___	Diabetes___	Angina___	Stroke___
Swollen Ankles___	Lupus____	Hepatitis/ Jaundice___	Allergies___
Kidney Diseases___	Frequently Tired___	Stomach Troubles___	Liver Disease___
Fainting / Seizures___	AIDS / HIV Infection___	Anemia___	Heart Trouble___
Asthma___	Thyroid Problem___	Emphysema___	Respiratory Problems__
Low Blood Pressure__	heart disease___	Cancer___	Tuberculosis___
Glaucoma___	Thyroid Problem___	Easily Winded___	Other_____

Any allergies to the following: Latex , Penicillin, Aspirin, Codeine, Local Anesthetics, Metal, Acrylic, Sulfa Drugs

Are you under medical treatment now? _____

Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____

_____.

Are you taking any medication(s)_____ If yes what medications are you taking? _____

_____.

Are you pregnant or think you may be pregnant? _____

Are you taking any contraceptives? _____

Are you Nursing? _____

AUTHORIZATION AND RELEASE- I certify that all the above information is to best of my knowledge. Providing incorrect information can be inefficient to my diagnosis. I understand that my dental insurance will pay directly to the dentist or dental group. I agree to be responsible for myself and or dependents for any services rendered in office.

X_____ Date_____