

Reservoir Smiles Dentistry Dr. Amye Shamburger

Patient Name: _____

Birth Date: _____

Date Created: _____

How long ago was your last dental visit?

- 6 months
 1 year
 5 years
 More than 10 years
 Never
 Other _____

Do you have a former Dentist?

Yes No

If yes

Do you have a family doctor? If yes, Please list your doctor's name.

Yes No

If yes

Are you under a physician's care now?

Yes No

If yes

Have you ever been hospitalized or had a major operation?

Yes No

If yes

Have you ever had a serious head or neck injury?

Yes No

If yes

Please list all medications you are currently taking.

Please list your current Pharmacy, phone number, and location:|

Women: Are you...

- Pregnant/Trying to get pregnant?
 Nursing?
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin
 Penicillin
 Codeine
 Acrylic
 Metal
 Latex
 Sulfa Drugs
 Local Anesthetics

Do you have any allergies other than what is listed above?

Yes No

If yes

Have you ever used crystal meth?

Yes No

If yes

Do you use any type of tobacco?

- Cigarettes
 Smokeless Tobacco
 Cigars

Do you have, or have you had, any of the following?

- | | | | |
|---|--|---|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No
Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No
Diabetes <input type="radio"/> Yes <input type="radio"/> No
Drug Addiction <input type="radio"/> Yes <input type="radio"/> No
Easily Winded <input type="radio"/> Yes <input type="radio"/> No
Emphysema <input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No
Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No
Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No
Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No
Frequent Cough <input type="radio"/> Yes <input type="radio"/> No
Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No
Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No
Genital Herpes <input type="radio"/> Yes <input type="radio"/> No
Glaucoma <input type="radio"/> Yes <input type="radio"/> No
Hay Fever <input type="radio"/> Yes <input type="radio"/> No
Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No
Heart Murmur <input type="radio"/> Yes <input type="radio"/> No
Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No
Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No
Hepatitis A <input type="radio"/> Yes <input type="radio"/> No
Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No
Herpes <input type="radio"/> Yes <input type="radio"/> No
High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
High Cholesterol <input type="radio"/> Yes <input type="radio"/> No
Hives or Rash <input type="radio"/> Yes <input type="radio"/> No
Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No
Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No
Kidney Problems <input type="radio"/> Yes <input type="radio"/> No
Leukemia <input type="radio"/> Yes <input type="radio"/> No
Liver Disease <input type="radio"/> Yes <input type="radio"/> No
Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No
Lung Disease <input type="radio"/> Yes <input type="radio"/> No
Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No
Osteoporosis <input type="radio"/> Yes <input type="radio"/> No
Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No
Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Shingles <input type="radio"/> Yes <input type="radio"/> No
Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Stroke <input type="radio"/> Yes <input type="radio"/> No
Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Ulcers <input type="radio"/> Yes <input type="radio"/> No
Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
|---|--|---|---|

Have you ever had any serious illness not listed

Yes No

If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____

X

Date: _____