Systemic Inflammatory Medical History Age: BP:

Please indicate if you have had any of the following:

Yes__	No__	Heart Attack	Yes__	No__	Rheumatoid Arthritis	Yes__	No__	Pregnant now
Yes__	No__	Stroke/TIA	Yes__	No__	COPD	Yes__	No__	Past miscarriage
Yes__	No__	Osteoporosis	Yes__	No__	GI Disorders/IBS/Crohns	Yes__	No__	Planning family
Yes__	No__	Hypertension	Yes__	No__	Periodontal Disease	Yes__	No__	Poor Sleep quality
Yes__	No__	Diabetes	Yes__	No__	High Carb diet	Yes__	No__	Snore
Yes__	No__	High Stress	Yes__	No__	Lack of exercise	Yes__	No__	Have CPAP
Yes__	No__	Smoker past 3 yr	Yes__	No__	Cancer	Yes__	No__	Wear the CPAP

Please indicate if Any family history applies:

Has a parent or grandparent had heart disease, heart attack, or stroke?	Yes:__	No__
Has a parent or grandparent had diabetes?	Yes:__	No__
Has a parent or grandparent had periodontal disease?	Yes:__	No__
Has a parent or grandparent had COPD?	Yes:__	No__
Has a parent or grandparent had cancer?	Yes:__	No__

General Medical History:

Yes__	No__	ADD/ADHD	Yes__	No__	Earaches	Yes:__	No__	Heart Surgery date:_____
Yes__	No__	AIDS or HIV+	Yes__	No__	Emotional concerns	Yes:__	No__	Hepatitis:_____
Yes__	No__	Allergies	Yes__	No__	Endocarditis	Yes:__	No__	Herpes (Oral)
Yes__	No__	Anemia	Yes__	No__	Epilepsy	Yes:__	No__	Fainting spells
Yes__	No__	Arthritis	Yes__	No__	Glaucoma	Yes:__	No__	Jaw Clicks/noise
Yes__	No__	Artificial Heart Valve	Yes__	No__	Headaches	Yes:__	No__	Kidney disease
Yes__	No__	Blood Disorders	Yes__	No__	Heart Angina	Yes:__	No__	Liver disease
Yes__	No__	Congenital heart valve	Yes__	No__	Heart Murmur	Yes:__	No__	Low blood pressure
Yes__	No__	Drug addictions	Yes__	No__	Pacemaker	Yes:__	No__	Lung disease
Yes__	No__	Mitral valve prolapse	Yes__	No__	Prosthetic joint	Yes:__	No__	Psychiatric care
Yes__	No__	Radiation therapy	Yes__	No__	Dry Mouth	Yes:__	No__	Rheumatic fever
Yes__	No__	Thyroid Disorder	Yes__	No__	Tonsils out	Yes:__	No__	Tuberculosis
Yes__	No__	Ulcers	Yes__	No__	GERD	Yes:__	No__	Birth control meds

Allergy Report:

Allergic to antibiotics/List_____

Allergic to metals? List if so_____

Allergic to latex? Yes___ No___ Allergic to other medication/List_____

General Health Information:

Yes__ No__ Are you in good general health now? Do you feel well?

Yes__ No__ Are you under the regular care of a physician at this time? Date of last physical: _____

Reason for regular medical care, if required: _____

Name of MD: _____ Phone: _____

Have you had a serious illness, been hospitalized? Explain briefly _____

Have you had chemo or radiation therapy for cancer? How long ago?_____ Type of CA:_____

Have you used tobacco/nicotine products in the past 2 years?_____

Been advised by MD to take antibiotic before dental appointment_____

Other important medical considerations _____

Please provide a list of all current medications (a medication card is available upon request)

Signed: _____ Date: _____

Printed name: _____

PATIENT REGISTRATION

Full Name:_____Single __Married __Divorced

Home Address:_____Phone: Home#_____ Cell#_____

_____Occupation:_____

_____Employer:_____

Birthdate:_____SS#_____

Spouse's Name:_____Employer:_____

Spouse's SS#:_____Spouse's birthdate:_____

Are there any other family members in our practice?_____

Person financially responsible for this account:_____

In case of emergency, whom do we contact:_____phone#:_____

Whom may we thank for this referral?_____

TREATMENT AND FINANCIAL CONSENT

I hereby authorize the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk.

If I have dental insurance to cover my treatment, I understand that it is a contract between me and the insurance carrier, and that it is being billed on my behalf as a courtesy. I understand that after 60 days, if the dental insurance has not paid, I will become responsible for paying that balance as well. All patient portions are due at time of service, and I am assigning benefits to LifeSMILES Dentistry of Gladwin. Any payment received by the doctor from my insurance company will be credited to my account or refunded to me if I have paid the fees incurred. I further understand that a billing fee may be added to my account for any overdue balance.

Patient Signature:_____
Date:_____