

Confidential Patient Information

(Please Print Legibly)

Date: _____

Personal Information

LastName: _____ First: _____ MI: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (H) _____ (W) _____ (cell/other)

Drivers Licence No. _____ BirthDate: _____ Sex: _____

Married ___ Divorced ___ Child ___ Single ___ Spouse Name: _____

How Do You Wish to be Addressed: _____ ReferredBy: _____

Person Responsible For Account

Name: _____ Relationship: _____ SS# _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (H) _____ (W) _____ (cell/other)

Dental Insurance Information

Primary Insurance Co: _____

Insurance Co Address: _____

Insurance Co Phone Number: _____ Policy/Group# _____

Employee: _____ SS# or ID# _____

Employee Birthdate: _____ Employer: _____

Signature of Patient or Parent if Minor

Date:

SmileS, Inc.

Dale F. Burke, D.D.S.

Bryan J Hirst, D.D.S.

Patient Name: _____

Medical History

Physician _____ Address _____ Phone _____

Are you in good health? _____ If no, explain _____

Have you been hospitalized in the past two years? _____ If yes, explain _____

Do you bleed excessively when cut? _____ Do you smoke? _____ If yes, how much? _____

Are you taking any medication, pills, or drugs? _____ If yes, please list _____

Are you allergic to any metals or latex? _____ If yes, what? _____

Do you now have, or have had any of the following?(If yes, describe under remarks section.)

	Yes	No		Yes	No
1. Heart Disease	_____	_____	15. Kidney Disease	_____	_____
2. High Blood Pressure	_____	_____	16. Hepatitis	_____	_____
3. Blood Disease	_____	_____	17. Asthma	_____	_____
4. Rheumatic Fever	_____	_____	18. Tuberculosis	_____	_____
5. Heart Murmur	_____	_____	19. AIDS or HIV positive	_____	_____
6. Diabetes	_____	_____	20. Are you pregnant?	_____	_____
7. Stroke	_____	_____	21. Allergy to:		
8. Epilepsy	_____	_____	a) Antibiotics	_____	_____
9. Arthritis	_____	_____	b) Pain Medication	_____	_____
10. Tumor History	_____	_____	c) Local Anesthetics	_____	_____
11. VD	_____	_____	d) Other	_____	_____
12. Nervous Disorders	_____	_____	If yes, what medications?	_____	
13. Radiation Treatment	_____	_____		_____	
14. Liver Disease	_____	_____		_____	

Dental History

Do you have any present dental complaints? _____ Where? _____

When was you last full-mouth x-ray taken? _____ Where? _____

When was your last cleaning? _____ Where? _____

Remarks

Patient Signature _____ Date _____