

MEDICAL INFORMATION

Please circle any of the following which you have had or have currently:

Alcohol or Drug abuse

Anemia or Hemophilia

Arthritis

Artificial Heart Valve/Joints

Asthma

Cancer or Tumor

Chemotherapy

Cold Sores

Diabetes

Epilepsy or Seizures

Fainting or Dizzy spells

Heart Murmur

Heart Problems

Hepatitis

High Blood Pressure

Kidney Disease

Latex Allergy

Liver Disease

+ HIV or Aids

Radiation Therapy

Respiratory Disease

Rheumatic Fever

Sinus Problems

Thyroid Disease

Other Medical Conditions (not listed above): _____

Have you been under the care of a medical doctor during the past two years? YES NO

If yes, for what reason? _____

Medical Doctor's Name and Phone Number: _____

Have you ever been told you need to be pre-medicated prior to dental work? YES NO

Are you currently taking any natural supplements, prescription or over-the-counter drugs? YES NO

If yes, list supplement/drug and dosage:

What medications are you allergic to? _____

Any other known allergies? _____

Tobacco Use: Do you currently use a form of tobacco? YES NO How much per day? _____

Marijuana Use: Are you currently using marijuana either as medical or recreational? YES NO

Women Only: Are you, or do you think you may be pregnant? YES NO

Due Date: _____ Are you currently nursing an infant? YES NO

Date: _____ Signature of patient or legal guardian: _____

DENTAL HISTORY INFORMATION

Tell us your story.....Brant Smiles Family Dentistry strives to provide optimal oral health to our patients. Please complete the dental survey to the best of your knowledge to help us get to know you and your oral health!

When was your last dental visit? _____

What was the reason for leaving previous office? _____

Are you having any dental problems currently? YES NO Do your gums bleed when you brush? YES NO

Do your gums bleed when you floss? YES NO Are you nervous to have dental treatment? YES NO

Have you had a bad dental experience at a dental office before? YES NO

What would you change about your smile?

Replacing missing teeth YES NO

Appearance of Smile YES NO

Straighter Teeth YES NO

Whiter Teeth YES NO

Gum Disease YES NO

Bad Breath YES NO

Other: _____

The information above is accurate and completed to be the best of my knowledge. I agree to inform the team of BRANT SMILES, of any changes in my medical condition.

I also agree that no employee at BRANT SMILES shall be held responsible for any error or omission that I may have made in the completion of my medical and dental information.

Sign: _____ Date: _____