

Health Information

Date: _____

Last Name: _____ First Name: _____ M.I. _____

Have you ever had any of the following? Please check all that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growths | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Veneral Disease | <input type="checkbox"/> Tuberculosis |
| | | | <input type="checkbox"/> Osteoporosis |

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No

Name of Physician: _____ Phone: _____

Please list all allergies (for example medications, foods, latex, etc) _____

Please list all medications you are currently taking: _____

Are you pregnant? ☐ Yes ☐ No

Please list any other health issues not listed above that need further clarification: _____

To the best of my knowledge, all of the answers concerning my health and dental information provided are true and correct. If I ever have changes in my health, I will inform the doctors at the next appointment without fail. I authorize the doctors & staff of SmilesNY to perform those procedures as deemed necessary or advisable to maintain my dental health.

Date: _____

Signature of patient, parent or guardian