Richard L. Smith, D.D.S.
1204 N.W. 69th TERRACE
GAINESVILLE, FLORIDA 32605
TELEPHONE: 331-6349

Mr. ☐ Mrs. ☐ Miss ☐ ☐ ______________________________

Last name First name Middle name

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Nickname__________ Age______ Date of Birth__________ SSN:__________

Residence ______________________________

Mailing Address ______________________________

Your Occupation______________________ Phone (Residence)__________

Employer______________________ Phone (Business)__________

Name of Spouse (Parent if single)______________________ Phone__________

Occupation______________________ Phone (Business)__________

Employer______________________________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name______________________ Phone__________

Please keep us advised of any change of job, address, marital or health status.

Payment is expected at the time services are rendered unless other arrangements are made.

Whom may we thank for referring you to us? ______________________________

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Name____________________ Date____________________

Age__________ Birthdate (Month, Day, Year)__________ SSN__________

1. Reason for visit?____________________
2. Date of your last: Dental treatment ____________________
   Prophylaxis (cleaning) ____________________
   Dental x-ray exam____________________
3. Were your previous experiences pleasant? __________ Unpleasant?__________
   Satisfactory?__________ Please Explain____________________
4. Do you brush daily? __________ Twice Daily?__________ More Often?__________
5. Do you floss daily? __________ Do you use a fluoride toothpaste? __________
6. Please check the following items regularly used in home care:
   - ❑ Hand Toothbrush
     - ❑ Soft ❑ Medium ❑ Hard Bristle
   - ❑ Electric Toothbrush
   - ❑ Oral Irrigator (WaterPik, Viajet, etc.)
   - ❑ Other____________________
   - ❑ Toothpicks
   - ❑ Stimudents
   - ❑ Rubber Tip
   - ❑ Proxabrush
   - ❑ Dental Floss
7. Past dental history (Please check all that apply.)
   - ❑ Tooth removal or oral surgery
   - ❑ Partial dentures (removable)
   - ❑ Crown and bridgework (fixed)
   - ❑ Endodontic treatment (root canal)
   - ❑ Restorations (fillings)
   - ❑ Full dentures
   - ❑ Periodontal treatment (gum care)
   - ❑ Orthodontic treatment (braces)
   - ❑ Special diagnostic exam (Please explain.)____________________
8. Do your gums bleed when you brush your teeth? ❑ Yes ❑ No
9. Do you get frequent blisters on your lips or in your mouth? ❑ Yes ❑ No
10. Are you aware of a swelling or a lump in your mouth? ❑ Yes ❑ No
11. Do you have a sore throat or white areas in your mouth that are slow to heal? ❑ Yes ❑ No
12. Do you grind, clench or grit your teeth? ❑ Yes ❑ No
13. Do you suffer from headaches, eye pain or migraine? ❑ Yes ❑ No
14. Does your jaw hurt when you chew? ❑ Yes ❑ No
15. Do you have ear pain or pain in front of your ears? ❑ Yes ❑ No
16. Does your jaw make noises that bother you or others? ❑ Yes ❑ No
17. Do you have pain or clicking when opening or closing the jaw? ❑ Yes ❑ No If yes, does the pain or discomfort interfere with your work or other activities? ❑ Yes ❑ No
18. Have you ever had treatment for TMJ (temporomandibular or jaw joint) pain or problems? ❑ Yes ❑ No
19. Are you aware of any oral habits such as nail biting, mouth breathing, gum chewing, lip biting, etc.? ❑ Yes ❑ No If yes, please indicate:____________________

PATIENT MEDICAL HISTORY FORM

The following information is to be reviewed by the doctor and will be held in strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat you. Our staff will be glad to help if you have any questions or need assistance.

20. How would you describe your general health?
    ❑ Poor ❑ Fair ❑ Good

21. Are you presently under the care of a physician? ❑ Yes ❑ No

If yes, why? ______________________________

22. Name of the physician: ______________________________

23. Address of the physician: ______________________________ Phone: ______________________________

24. Date of the last medical examination? ______________________________

Month Year

25. Please list any hospitalizations within the last five years:

Year	City	Reason	Complications

26. Please list all MEDICATIONS you are now taking, including aspirin and over-the-counter drugs, vitamins, etc.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

27. Have you ever had a series of shots or injections other than immunizations? ❑ Yes ❑ No

28. Have you ever been told not to take novocaine or any other medication? ❑ Yes ❑ No

29. Do you have any allergies? Please check all that apply. ❑ Yes ❑ No

❑ Antibiotics (penicillin, etc.) ❑ Novocaine or other dental anesthetics

❑ Codeine ❑ Aspirin

❑ Other drugs or medicines ______________________________

❑ Foods, metals, pollens or other ______________________________

30. Do injuries or cuts take longer to heal now than they did previously? ❑ Yes ❑ No

31. Have you ever had frequent nosebleeds or prolonged bleeding following tooth removal or minor cuts? ❑ Yes ❑ No

32. Are you now or have you ever taken anticoagulants (blood thinners)? ❑ Yes ❑ No

33. Have you ever had a blood transfusion? ❑ Yes ❑ No

34. Did you receive a blood transfusion before March 1985? ❑ Yes ❑ No

35. Do you have any unusual rash, splotches or spots? ❑ Yes ❑ No

36. Have you ever been treated for drug or alcohol addiction? ❑ Yes ❑ No

37. Do you drink alcohol? ❑ Yes ❑ No

If yes, how often? ______________________________

38. Are you currently using unprescribed "street drugs"? (Interactions with anesthetics can be life-threatening.) ❑ Yes ❑ No

39. Do you smoke? ❑ Yes ❑ No

If yes, how much? ______________________________

40. Do you chew tobacco or use snuff? ❑ Yes ❑ No

If yes, how often? ______________________________

41. Is there a history of diabetes in your family? ❑ Yes ❑ No

42. Are you thirsty most of the time? ❑ Yes ❑ No

43. Do you urinate frequently, especially at night? ❑ Yes ❑ No

44. Does your mouth feel dry or do you have a burning sensation of lips or tongue? ❑ Yes ❑ No

45. Have you gained or lost much weight recently? ❑ Yes ❑ No

46. Do you have thyroid problems or take thyroid tablets? ❑ Yes ❑ No

47. Have you taken or been given injections or tablets of steroids such as cortisone or prednisone? ❑ Yes ❑ No
48. Have you been told that you have kidney or bladder trouble? ❑ Yes ❑ No
49. Have you had eye trouble or a change in vision recently? ❑ Yes ❑ No
50. Have you ever had chemotherapy or radiation therapy (underline which)? ❑ Yes ❑ No

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE FOLLOWING CONDITIONS OR DISEASE? IF YES, PLEASE CIRCLE.

	Yes	No
51. AIDS / ARC / HIV +?	❑	❑
52. Hepatitis (A, B, C (NANB), Delta)?	❑	❑
53. Persistent flu-like symptoms (diarrhea, fever, swollen lymph nodes, cough etc.)?	❑	❑
54. Veneral disease (syphilis, genital herpes, gonorrhea)?	❑	❑
55. Liver disease, jaundice?	❑	❑
56. Heart disease?	❑	❑
57. Heart trouble?	❑	❑
58. High blood pressure?	❑	❑
59. Low blood pressure?	❑	❑
60. Shortness of breath?	❑	❑
61. Swelling of ankles or feet?	❑	❑
62. Heart attack?	❑	❑
63. Angina pectoris (pain, pressure or tight feeling in chest)?	❑	❑
64. Rheumatic fever?	❑	❑
65. Surgical blood shunts?	❑	❑
66. Artificial heart valves or pacemaker?	❑	❑
67. Heart valve problems?	❑	❑
68. Mitral valve prolapse?	❑	❑
69. Artificial joints?	❑	❑
70. Heart murmur?	❑	❑

	Yes	No
71. Fainting spells, convulsions, epilepsy, or seizures?	❑	❑
72. Stroke?	❑	❑
73. Scarlet fever?	❑	❑
74. Asthma, hay fever, sinusitis, or frequent sore throats?	❑	❑
75. Tuberculosis, pneumonia, emphysema or cough up blood?	❑	❑
76. Parkinson's disease	❑	❑
77. Diabetes?	❑	❑
78. Back problems?	❑	❑
79. Painful and/or swollen joints?	❑	❑
80. Arthritis?	❑	❑
81. Glaucoma?	❑	❑
82. Ulcers?	❑	❑
83. Typhoid fever?	❑	❑
84. Tonsillitis?	❑	❑
85. Mononucleosis?	❑	❑
86. Leukemia?	❑	❑
87. Malignancies (cancers) or tumors?	❑	❑
88. Anemia?	❑	❑
89. Measles or mumps?	❑	❑
90. Do you have a DNR order?	❑	❑
91. Do you now or have you ever taken Fosamax, Actonel, Boniva or an osteoporosis treatment?	❑	❑

If female, are you pregnant? ❑ ❑

Expected delivery date: ______________________

If female, are you nursing? ❑ Yes ❑ No

THE INFORMATION GIVEN IN THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I HEREBY GIVE MY CONSENT TO PERFORM NECESSARY DIAGNOSTIC TESTS INCLUDING X RAYS.

______________________________ ______________

Signature of patient, parent or guardian Date

Please return this completed form to the receptionist. Thank you for allowing us to serve you dental health care needs.

MEDICAL HISTORY REVIEW: I HAVE REVIEWED THIS MEDICAL HISTORY AND HAVE ADDED ANY CHANGES SINCE MY LAST VISIT

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

Signature ____________________ Date ____________________

PLEASE DO NOT WRITE BELOW. (DOCTOR'S USE ONLY)

Summary: ____________________