**Peoria Healthy Smiles**
**Plaza Del Rio Medical Center**
**13660 N 94th Drive Suite E3**
**Peoria AZ 85381-4209**
**Phone 623-974-4799**

**PATIENT INFORMATION** Today's Date:_____-_____-201__

To help us render proper dental treatment to you, please fill in all applicable information.
Thank you for your cooperation. Please ask if you have any questions.

Name:______________________________ Title:(Mr,Mrs,etc)_____ Sex:__ Date of birth:_____-_____-_____
(last) (first) (MI)

Name you'd like us to call you_________________ SS#:_____-_____-_____ Phone:(_____)_____-_______

Local Address:________________________________________ City: ________________ Zip: __________

Out-of-Town Addr:_______________________________ City,State: _________________ Zip: __________

Cell:(_____)_____-______ Out-of-Town Phone:(_____)_____-______ E-mail:_____________________________

For confirmation of your future appointments, would you prefer: ❑ E-mail ❑ Text ❑ Home Phone ❑ Cell

Employer:_____________________ Occupation:__________________ Bus. phone:(______)______-_______

Business address: ___________________________________ City:___________________ Zip: _________

Marital status:______ Spouse's name:____________ Spouse's Employer:___________________________

Spouse's business address:_____________________________________________________________

If another party is financially responsible for your obligations, please list name, address and phone of

that party: _________________________________________________________________________

Dental insurance? ❑ Yes ❑ No Ins. company:___________________ Policy Holder(s): ❑ Self ❑ Spouse

Whom may we thank for referring you to our office?______________________________________________

Person to contact in case of emergency:________________________________ Phone:(____)_____-_______

**MEDICAL HISTORY**

General health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Physician: Name:___________________________ City:______________ Specialty:________________

Most recent blood pressure reading (if known):______/______ Date of reading: _________

Medications and supplements you are taking: Check here if none ❑

Name of medication Purpose

______________________________________

______________________________________

______________________________________

______________________________________

______________________________________

Any known medical allergies? ❑ Yes ❑ No

If Yes, check if you are allergic to:

❑ Penicillin
❑ Codeine
❑ Local injected anesthetics
❑ Latex
❑ Metals
❑ Other medication:_________________

(OVER PLEASE)

Check if you have ever experienced or been treated for:

❑ Artificial heart valve
❑ Artificial joint
❑ Kidney dialysis
❑ Alzheimer's
❑ Angina
❑ Asthma
❑ Bone density drug history
❑ Cancer / Chemotherapy
❑ Clotting disorder
❑ Congestive heart disease
❑ Diabetes
❑ Epilepsy or Seizure
❑ Fainting
❑ Fever blisters / Cold sores
❑ Frequent headaches
❑ HIV+ / AIDS
❑ Heart attack
❑ Hepatitis
❑ High blood pressure
❑ Kidney problems
❑ Pacemaker
❑ Parkinson's
❑ Psychiatric problems
❑ Radiation therapy
❑ Sexually transmitted disease
❑ Shingles
❑ Sinus problems
❑ Sleep apnea
❑ Use CPAP
❑ Snoring
❑ Stroke / TIA
❑ Substance dependence
❑ Thyroid problems
❑ Tuberculosis

Women: ❑ Current pregnancy - what month?____

Please list dates and reasons for any surgery or major hospitalizations you have had:

________________________________________________________________________________

Other medical problems not mentioned above:____________________________________________

Do you need to be premedicated with antibiotics before dental treatment? ❑ Yes ❑ No ❑ Not sure

## DENTAL HISTORY

What is the reason for your visit?_________________________________

When was your last dental visit?______________ When was your last scaling (cleaning)?____________

Have you ever had any problem associated with previous dental treatment? Yes ❑ No ❑

If so, please explain:________________________________________________________________

Would you like to prevent dentures? ❑ Yes ❑ No Do you have any dental implants? ❑ Yes ❑ No

Please check any of the following that apply to you:

❑ Bad breath
❑ Bleeding gums
❑ Dry mouth
❑ Floss daily
❑ Gum treatments or surgery
❑ Orthodontic treatment
❑ Pain in jaw joints
❑ Prefer no "Novocaine"
❑ Sensitive teeth
❑ Teeth clenching or grinding
❑ Tooth whitening history
❑ Unhappy with teeth appearance
❑ Wear nightguard or NTI

❑ Smoking If so: ❑ Cigarettes ❑ Pipe ❑ Cigars

If you wear full or partial **dentures**, please give the year(s) your current sets were delivered:

Upper: ❑ Full ❑ Partial Year delivered: ________ Lower: ❑ Full ❑ Partial Year delivered: ________

Other comments which may help us in your treatment:_______________________________________

________________________________________________________________________________

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. If my account becomes delinquent, I agree to be responsible for all finance charges, a 35% collection fee and/or attorney's fees that accrue.**

**Patient (or responsible party) signature**________________________________