Luminous Smile, Corp

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Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ *PREMED- Amox	☐ *PREMED- Clind	☐ *PREMED- Other	☐ ADHD
☐ Allergies	☐ Allergy- Aspirin	☐ Allergy- Codeine	☐ Allergy- Erythro
☐ Allergy -Latex	☐ Allergy- PCN	☐ Allergy Sulfa	☐ Allergy-Nsaids
☐ Anemia	☐ Anxiety	☐ Arthritis	☐ Artificial Joints
☐ Aspirin	☐ Asthma	☐ Augmentin	☐ Azithromycin
☐ Blood Thinner	☐ Cancer	☐ Ceclor	☐ Codeine
☐ Codeine Allergy	☐ Daily ASA	☐ Diabetes	☐ Dizziness
☐ Do not recline	☐ Doxycycline	☐ Epilepsy	☐ Erythromycin
☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma	☐ Growths
☐ Hay Fever	☐ Head Injuries	☐ Hearing Impaired	☐ Heart Arrhythmia
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis	☐ High Blood Pressure
☐ High Cholestero	☐ HIV	☐ Hydrocodone	☐ Iodine
☐ Jaundice	☐ Joint Replacements	☐ Keflex	☐ Kidney Disease
☐ Latex	☐ Levaquin	☐ Liver Disease	☐ Low Blood Pressure
☐ Lupus	☐ Mental Disorders	☐ Migraines	☐ Morphine
☐ MRSA	☐ Multiple Sclerosis	☐ N2O	☐ Nervous Disorders
☐ NO EPI	☐ No Steroids	☐ Other	☐ Pacemaker
☐ Penicillin Allergy	☐ Prednisone	☐ Pregnancy	☐ Radiation Treatment
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ Stomach Problems	☐ Strawberries	☐ Stroke	☐ Sulfa
☐ Tetracycline	☐ Tetracycline Allergy	☐ Thyroid Problem	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	☐ Wheelchair Bound

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____

_____

_____

_____

Allergies not listed:

_____

_____

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment below:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Response Date: _____