Dr. J. Bradford Smith, D.D.S.
Family and Cosmetic Dentistry

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Patient Information

Patient Name: _____ Birthdate: _____ Age: _____ SS#: _____

Address: _____ Email: _____

Home #: _____ Cell #: _____ Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Employer: _____ Work #: _____ Occupation: _____

Emergency Contact: _____ Relation: _____ Phone: _____

DO YOU:

	YES	NO
Clench or grind your teeth while awake or asleep? Have tired jaws, especially in the morning?	◯	◯
Have pain in the jaw joint area and/or experience clicking or popping of the jaw?	◯	◯
Have difficulty in opening and closing your mouth?	◯	◯
Have headaches, neck aches, or shoulder aches frequently?	◯	◯
Snore loudly (louder than talking or loud enough to be heard through closed doors)?	◯	◯
Often feel ***tired***, fatigued, or sleepy during daytime?	◯	◯
Has anyone observed you stop breathing during sleep?	◯	◯
Have or are you being treated for high blood pressure?	◯	◯
*If you answered **yes** to 3 or more questions above, Have you had a **sleep study**?*	◯	◯

- If yes, when was your study performed and what were the results? _____

Medical History

Physician's Name: _____ Office Phone #: _____

Are you currently taking any **prescription or over-the-counter drugs**? ◯ YES ◯ NO - If yes, please list: _____

_____

Have you been hospitalized or had a serious illness within the past **2** years? ◯ YES ◯ NO - Explain: _____

_____

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE AT THE PRESENT OR HAVE HAD IN THE PAST:

☐ ACID REFLUX ☐ AIDS/HIV ☐ ANGINA PECTORIS ☐ ASTHMA ☐ ARTIFICIAL HEART VALVE ☐ ARTHRITIS
☐ BRONCHITIS ☐ CHEMOTHERAPY ☐ DIABETES – TYPE - ____ ☐ EMPHYSEMA/COPD ☐ EPILEPSY/SEIZURES ☐ FREQ. HEADACHES
☐ HBPV ☐ OSTEOPOROSIS ☐ HEART DISEASE/ATTACK ☐ HIGH BLOOD PRESSURE ☐ HEPATITIS: TYPE - _____ ☐ PACE MAKER
☐ STROKE TIA ☐ KIDNEY PROBLEMS ☐ JOINT REPLACEMENTS ☐ LOW BLOOD PRESSURE ☐ THYROID PROBLEMS ☐ TUBERCULOSIS
☐ ULCERS/COLITIS ☐ LIVER PROBLEMS ☐ RADIATION THERAPY ☐ SHINGLES VIRUS – WHEN? _____ ☐ SINUS PROBLEMS/ALLERGIES
☐ PREMED NEEDED FOR CLEANINGS ☐ SLEEP APNEA – Year diagnosed? _____ AND Do you currently use a CPAP? _____

CHECK ANY OF THE FOLLOWING THAT HAVE CAUSED ALLERGIES/ADVERSE REACTIONS:

☐ PENICILLIN ☐ TETRACYCLINE ☐ ERYTHROMYCIN ☐ SULFA ☐ CODEINE ☐ VALIUM ☐ BARBITURATES ☐ LATEX ☐ RED DYE
☐ ASPIRIN ☐ LOCAL ANESTHETICS ☐ NSAID/ADVIL/MOTRIN ☐ OTHER, Please Explain: _____

FEMALE PATIENTS:

ARE YOU PREGNANT NOW? ◯ YES ◯ NO PRACTICING BIRTH CONTROL? ◯ YES ◯ NO PLAN TO BECOME PREGNANT? ◯ YES ◯ NO

Any medical history not listed above? Please explain: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of changes in my medical status. I do hereby authorize and request for myself or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorized the administration of those local anesthetic or pre-medications which may be deemed advisable. I understand and agree that it is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

_____ _____ _____

Patient or Responsible Party's Signature **Print Patient or Responsible Party's Name** **Date**