Northern Smiles Dentistry & Orthodontics
7501 North 16th Street, Suite 100, Phoenix, AZ 85020

Patient Information

Patient Name: _____ SSN#: _____ Birth date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (Home): _____ (Work): _____ (Cell): _____

E-Mail: _____ Employer: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Emergency Contact: _____
(Name) (Relationship) (Phone Number)

Dental Insurance: _____ Group #: _____ ID#: _____

Health Information

Do you need to Premedicate for dental appointments? ☐ Yes ☐ No If so, why? _____

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

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
  - ☐ Radiation Therapy
  - ☐ Chemotherapy
  - ***Last treatment*** _____
- ☐ Chemical Dependency
- ☐ Cortisone Treatment
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Emphysema or COPD
- ☐ Epilepsy or Seizures
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Problems
  - ***Describe*** _____
- ☐ Hemophilia/Bleeding
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorder
- ☐ Osteoporosis
  - ☐ taking bisphosphates
- ☐ Pacemaker
- ☐ Pregnancy
  - Due Date _____
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Sinus Problems
- ☐ Stomach Problems/GERD
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

OTHER:
- ☐ _____
- ☐ _____
- ☐ _____

Please list all medications (prescription and OTC):

☐ **None**

_____
_____
_____
_____

Please list all allergies:

☐ **None**

_____
_____
_____
_____

Patient Signature: _____ Relationship to Patient: _____

Date: _____