SmilePartners
Healthy smiles, healthy lives

Today's date:_____

Name:_____ Birthdate:_____ Age:_____

Address:_____ Phone:_____

Email:_____ Cell:_____ Home phone:_____

Welcome to Smiles for Life. Please fill out this form as best as you can. The information is essential for our staff to provide care in a manner that is compatible with your overall health.

Medical History

Primary care provider:_____ Phone:_____

Are you currently under his or her care now? YES NO

Reason:_____

Current medication(s):_____
_____

List drug allergies:_____

Have you been hospitalized or had a serious illness in the past five years? YES NO

If so, please explain:_____

Have you ever been told you needed to take antibiotics before a dental appointment? YES NO

Reason:_____

Have you ever been told to stop taking a medication before a dental appointment? YES NO

Medication:_____

How would you describe your general health? Excellent Good Fair Poor

(More)