LIFESMILES DENTAL

www.lifesmilesdds.com
13108 W. Persimmon Ln. • Boise, ID 83713
frontdesk1@lifesmilesdds.com
(208)377-2160

Please review and update your information

Chart#:

FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____ (Preferred Name)

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

Best time to call: _____

Address: _____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Employer Name: _____

_____

Primary Dental Insurance

Name of Insured: _____ (Last)

_____ (First) ____ (MI)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Do you have additional Dental Insurance? If yes, please list below.

_____

_____

Medical Infomation

In an emergency who should be notified? Please enter name and phone number below. *

_____

_____

Name of your physician, phone number, and your most recent physical exam. *

_____

_____

Have there been any changes to your medical history since your last dental visit? * ◯ Yes ◯ No

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

☐ High/Low Blood Pressure	☐ Heart Attack	☐ Heart Disease/Defect
☐ Cardiac Pacemaker	☐ Angina, Chest Pains	☐ Fainting/ Seizures
☐ Epilepsy/ Convulsions	☐ Stroke	☐ Respiratory/ Lung Problems
☐ Tuberculosis	☐ Asthma	☐ Arthritis
☐ Joint Replacement or Implant	☐ Diabetes, Type I or II	☐ Anemia
☐ Glaucoma	☐ Cancer or Leukemia	☐ Liver Disease
☐ Kidney Disease	☐ Parkinsons	☐ Dementia
☐ Depression	☐ AIDS or HIV Infection	☐ Stomach troubles/ Ulcers
☐ Thyroid Problems	☐ Allergic reactions to medications, latex or other	☐ FEMALE: Pregnant

Please explain all medical conditions or if any of the alerts selected above need further clarification, please describe below.

Do you take antibiotic premedication for your dental visits? If yes, please explain.

List all medications, drugs, pills or herbal remedies, including regular dosages of aspirin.

Please list all allergies.

Human Papilloma Virus (HPV)

Have you had the HPV vaccination? ◯ Yes ◯ No

If you have children, have they had the HPV vaccination? ◯ Yes ◯ No

Sleep Quality

Do you sleep well?	◯ Yes	◯ No
Have you ever been told you snore at night?	◯ Yes	◯ No
Have you been told you hold your breath or gasp for air while sleeping?	◯ Yes	◯ No
Have you been diagnosed with sleep apnea?	◯ Yes	◯ No
If yes, are you being treated?	◯ Yes	◯ No

☐ *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.

Response Date: _____