**SMILES BY DESIGN, THE OFFICE OF GREG MCELROY, DDS**
**OFFICE: (760) 479-9898 FAX: (760) 479-0053**
**Email: office@drmcelroy.com Website: drmcelroy.com**

## Patient Information

Patient Name: ______________________________ Date:________
First MI Last Preferred Name

Email: ______________________________ Gender: Male / Female Marital Status:__________

Social Security #:______________________________ Birth Date:______________________________

Phone (Home): ______________ (Work):______________Ext:__________(Cell): ______________

Address: ______________________________
Street Apartment #

______________________________
City State Zip Code

## Responsible Party Information

☐ ***SAME AS ABOVE*** Name: ______________________ Relationship To Patient: ______________

Social Security #:______________________________ Birth Date:______________________________

Phone (Home):______________ (Work):______________ Ext:__________ (Cell) :______________

Address:______________________________
Street City State Zip Code

## Referral Information

Whom may we thank for referring you to our practice? ______________________________

## Health Information

Date of last dental visit:______________________ Reason for this visit: ______________________

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

YES ❑ NO ❑ AIDS / HIV
YES ❑ NO ❑ Allergic
YES ❑ NO ❑ Medication / Latex / Food
______________________________
YES ❑ NO ❑ Acne Medication
YES ❑ NO ❑ Anemia
YES ❑ NO ❑ Arthritis
YES ❑ NO ❑ Artificial Joints
YES ❑ NO ❑ Asthma
YES ❑ NO ❑ Blood Disease
YES ❑ NO ❑ Blood Thinner Medication
YES ❑ NO ❑ Cancer
YES ❑ NO ❑ Radiation / Chemo
DIABETES - TYPE 1 OR 2
YES ❑ NO ❑ Insulin__________
YES ❑ NO ❑ Dizziness

YES ❑ NO ❑ Epilepsy
YES ❑ NO ❑ Excessive Bleeding
YES ❑ NO ❑ Fainting
YES ❑ NO ❑ Glaucoma
YES ❑ NO ❑ Hay Fever
YES ❑ NO ❑ Head Injury
YES ❑ NO ❑ Heart Disease
HEART ATTACK__________
YES ❑ NO ❑ Heart Murmur
YES ❑ NO ❑ Hepatitis - Type____
YES ❑ NO ❑ High Blood Pressure
YES ❑ NO ❑ Low Blood Pressure
YES ❑ NO ❑ Kidney Disease
YES ❑ NO ❑ Liver Disease
YES ❑ NO ❑ Mental Disorders
YES ❑ NO ❑ Nervous Disorders

YES ❑ NO ❑ Pacemaker
YES ❑ NO ❑ Pregnant
Due Date:______________
YES ❑ NO ❑ Respiratory Problems
YES ❑ NO ❑ Rheumatic Fever
YES ❑ NO ❑ Rheumatism
YES ❑ NO ❑ Sinus Problems
YES ❑ NO ❑ Stomach Problems
YES ❑ NO ❑ Stroke__________
YES ❑ NO ❑ Thyroid – Low / High
YES ❑ NO ❑ Tuberculosis
YES ❑ NO ❑ Ulcers
YES ❑ NO ❑ Venereal Disease
YES ❑ NO ❑ I have used Fen-Fen

Premedication Required
YES ❑ NO ❑
❑ Heart__________
❑ Joint__________

❑ Sleep Apnea
CPAP - YES ❑ NO ❑
Snore Appliances
YES ❑ NO ❑
Type:______________

- Are you taking any medications? YES ❑ NO ❑
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? YES ❑ NO ❑
  If yes, please explain: ______________________________
- Are you now under the care of a physician other than regular check-ups? YES ❑ NO ❑
  If yes, please explain: ______________________________
- Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? YES ❑ NO ❑
  If yes, please explain: ______________________________
- Have you ever had any serious problems associated with previous dental treatment? YES ❑ NO ❑
  If yes, please explain: ______________________________