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Name	
Address	
Birth date	
Email	
Employer	
Previous Dentist's Name	

Social Security #	
City State Zip	
Home Phone	
Work Phone	
Cell Phone	
Current Physician's Name	

Responsible Party	
Address	
Birth date	
Email	
Employer	

Social Security #	
City State Zip	
Home Phone	
Work Phone	
Cell Phone	

Whom may we thank for referring you?

Medical History

Are you allergic to any of the following? Please circle for **yes**.

Aspirin Condeine Other Medications	Sulfa Penicillin	Latex Jewelry	Barbiturates Erythromycin	Dental Anesthetics Metals
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Do you have, or have you had, any of the following? Please circle for **yes**.

AIDS/HIV+	Cortisone Medicine	Hemophilia	Renal Dialysis
Alzheimer's Disease	Diabetes	Hepatitis A	Rheumatic Fever
Anaphylaxis	Drug Addiction	Hepatitis B or C	Rheumatism
Anemia	Easily Winded	Herpes	Scarlet Fever
Angina	Emphysema	High Blood Pressure	Shingles
Arthritis/Gout	Epilepsy/Seizures	Hives or Rash	Sickle Cell Disease
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sinus Trouble
Artificial Joint	Excessive Thirst	Irregular Heartbeat	Spinal Bifida
Asthma	Fainting/Dizziness	Kidney Problems	Stomach/Intestinal Disease
Blood Disease	Frequent Cough	Leukemia	Stroke
Blood Transfusion	Frequent Diarrhea	Liver Disease	Swelling of Limbs
Breathing Problem	Frequent Headaches	Low Blood Pressure	Thyroid Disease
Bruise Easily	Genital Herpes	Lung Disease	Tonsillitis
Cancer	Glaucoma	Mitral Valve Prolapse	Tuberculosis
Chemotherapy	Hay Fever	Pain in Jaw Joints	Tumors or Growth
Chest Pains	Heart Attack/Failure	Parathyroid Disease	Ulcers
Cold Sores	Heart Murmur	Psychiatric Care	Veneral Disease
Congenital Heart Disorder	Heart Pace Maker	Radiation Treatments	Yellow Jaundice
Convulsions	Heart Trouble/Disease	Recent Weight Loss	

Have you ever had any surgery, hospital stays or any serious illness not listed above? If yes, please explain:

Please list any medications or herbal remedies you are currently taking.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

Date:
