

STEPHEN P. SMYTHE, DMD, PLLC FAMILY DENTAL CARE

SOUTHEND PROFESSIONAL OFFICE PARK 5141 DIXIE HIGHWAY, SUITE 101 • LOUISVILLE, KY 40216 • (502) 448-2733

Last First Mode 3. Home Phone Birthdate City Social Security # State Zip 4. E-Hail Address Cell # Work Phone 5. Whom may we thank for referring you? 6. Is another member of your family or relative a patient in our practice? 7. Person Responsible for Payment 8. Address Street City State Zip 9. Relationship to Patient (Iff minor, list parents names:) 10. Social Security # (Iff minor, list parents names:) 11. Birthdate (Iff minor, list parents names:) 12. Driver's License # Father First Last 13. Home Phone Mother First Last 14. Employer Mother 15. Work Phone 16. Battent's Spouse Name 17. Spouse's Employer 18. Occupation Has Occupation 19. Work Phone 19. Work Phone 19. Work Phone 19. Insured's Birthdate 20. Insured's Name (employee) 21. Insured's Sittidates (iff different from above) 22. Insured's Social Security # 24. Insured's Social Security # 24. Insured's Social Security # 25. Insured's Social Security # 26. Insurance Co. Name Group Name EMERGENCY INFORMATION 27. Local Friend or Relative not living with you 28. Address	1. Patient's Name				Driver's L	_icense #		
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MEDICAL HISTORY

1.	YES NO							
2.	If yes, for what reason? Please provide the name, address, and telephone number of your physician.							
3.	YES NO							
4.	If yes, please list Have you ever had excessive b		YES NO					
	-		prior to dental treatment? YES NO					
		ng, rash, swelling of hands, feet or ey						
			YES NO					
7.	Of the following which you have	e had or have at present:						
	☐ Heart Failure	_	Di Boin in Joyy Jointo					
	☐ Heart Disease or Attack	☐ Shortness of Breath	Pain in Jaw Joints					
	_	☐ Emphysema	☐ Allergic to Latex					
	Angina Pectoris (chest pain)	☐ Hepatitis B (Serum)	☐ High Blood Pressure					
	Tuberculosis (TB)	Liver Disease	☐ Heart Murmur/Mitral Valve Prolapse					
	Asthma	☐ Allergies or Hives	☐ Bruise Easily					
	Rheumatic Fever	☐ Diabetes	☐ Blood Transfusion					
	☐ Scarlet Fever	☐ Thyroid Disease	☐ Drug Addiction					
	Artificial Heart Valve	☐ X-Ray or Cobalt Treatment	☐ Hemophilia					
	Heart Pacemaker	☐ Chemotherapy (Cancer,Leukemia)	☐ Venereal Disease (Syphilis, Gonorrhea)					
	Heart Surgery	Arthritis	Cold Sores or Fever Blisters					
	Artificial Joint	Rheumatism	☐ Epilepsy or Seizures					
	☐ Anemia	Cortisone Medication	☐ Fainting or Dizzy Spells					
	Stroke	Glaucoma	Nervousness					
	☐ Kidney Trouble	Hepatitis A (Infectious)	Psychiatric Treatment					
	☐ Ulcers	☐ HIV Positive (AIDS)	☐ Sickle Cell Disease					
8.	List all medications you are taking	at this time.						
9.	Are you a smoker?		YES NO					
	10. Do you use or have you ever used recreational drugs?							
	•	ke a walk, do you ever have to stop because						
			YES NO					
12.	YES NO							
13.	YES NO							
14.	YES 🛄 NO							
15.	YES NO							
	YES NO							
17.	7. Do you have any disease, condition or problem not listed? If so, please list							
18.	. Women: Are you pregnant: TYES	S ☐ NO If yes, what month are you due? _						
			YES 🛄 NO					

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.