PAUL R. STANOVICK, DDS
Smile by Stano

Patient Name: _____ Date of Birth ___/___/___
Sex ____ Social Security Number_____ Marital Status_____

Home Number_____ Cell Phone Number_____
Work Number_____ Email _____
Emergency Contact Name & Number_____

Home Address _____
City_____ State_____ Zip _____

Employer_____

Whom may we thank for referring you to our office? _____

Insurance Information – **PLEASE PROVIDE COPY OF INSURANCE CARD & DRIVERS LICENSE**
Dental Insurance Company_____
Policy Holder Name _____
Policy Holder SSN & DOB _____& ___/___/___
Policy Holder Employer _____

Medical Health History:

Do you have, or have you had any of the following? (Please check any that apply)

- ☐ Are you required to Pre-Medicate before any dental treatment? If so, what do you premedicate with and for how long (years)? _____
- ☐ Blood Problems (Anemia)
- ☐ History of Infective Endocarditis (infection of heart valves)
- ☐ Heart Murmur, MVP, heart defect, heart problems (circle any that apply)
- ☐ Heart Pacemaker, if so when was it placed? _____
- ☐ Stroke, if so when? _____
- ☐ Are you currently taking blood thinners, if so please list? _____
- ☐ Bone or joint problems
- ☐ Artificial joint, valves, stents, if so please explain? _____
- ☐ High or low blood pressure (circle which one applies)
- ☐ Tuberculosis or lung issues
- ☐ Kidney disease
- ☐ Hepatitis

PLEASE SEE OTHER SIDE

- ☐ Diabetes TYPE 1 or TYPE 2 (circle one), medication used to treat it? _____
- ☐ High Cholesterol, if so, are you on a medication? _____
- ☐ Autoimmune Disorder, if so what type? _____
- ☐ Epilepsy or Neurological Disease
- ☐ Thyroid Issues HYPO or HYPER (circle one), medication used to treat it? _____
- ☐ Arthritis or Rheumatoid arthritis
- ☐ Herpes or cold sores
- ☐ Mouth Ulcers if so, how often? _____
- ☐ AIDS or HIV positive
- ☐ Cancer/Tumor, if so what type: _____
- ☐ Abnormal bleeding after any surgery (heavy bleeder)
- ☐ Blood Disorders, if so please explain: _____
- ☐ Asthma, if so, what inhalers are used? _____
- ☐ Acid Reflux, if so, how often & is any medication used? _____
- ☐ Sleep Issues that require a sleep device
- ☐ TMJ, Sinus, Wisdom Teeth Issues, if so, how often? _____
- ☐ Grinding or Clenching teeth, is a guard used? _____
- ☐ Dry mouth
- ☐ Pregnant
- ☐ Do you smoke, vape, or use chewing tobacco? (circle which ones apply)
- ☐ Do you have an issue with local anesthetics if so please specify? _____
- ☐ Are you taking Osteoporosis (bone density) medications, if so, what is the medication and how long have you been on it? _____
- ☐ Do you have a **Red Dye Allergy?** (we do have dental prophy paste with red dye)
- ☐ Do you have a **LATEX ALLERGY**? (we use latex gloves otherwise)

Name of your primary care doctor: _____ Number: _____

Please list any **medications** & **vitamins** you are currently taking:

Please list any **allergies, drug allergies**, **sensitives to drugs**, or **LATEX Allergies**:

Signature of patient (or parent) _____ Date ___/___/___

When signing this you are consenting that all information listed above is correct and filled out to the best of your knowledge.