smile FLOSS care
HINTZ
BRUSH FAMILY DENTISTRY
est. 2008

309 N Ankeny Blvd
Ankeny, Iowa 50023

Name: _____

Medical History

Primary physicians name: _____ Physicians Phone: _____ Date of last visit: _____

Do you have any current health problems? **Yes** ___ **No** ___ If yes, explain: _____

_____

Are you currently taking any medications? **Yes**___ **No** ___ If yes, what? _____

_____

Have you ever had any serious illness/ operations/ blood transfusion? **Yes**___ **No**___ If yes, specify: _____

_____

Are you pregnant? **Yes**___ **No** ___ Due Date: ___/___/_____
Are you nursing? **Yes**___ **No** ___ Are you taking birth control? **Yes**___ **No** ___

Do you have any allergies? Yes___ **No** ___ If yes, please list: _____

Please indicate if you have any of the following:

ADD/ADHD		Fainting		Rheumatic Fever		Anemia	
Glaucoma		Shortness of breath		Arthritis, Rheumatism		Headaches	
Sickle Cell		Artificial Heart Valves		Heart Murmur		Skin Rash	
Artificial Joints		Heart Problems		Stroke		Asthma	
Hemophilia		Feet/Ankle Swelling		Blood Disease		Thyroid Problem	
Cancer		High Blood Pressure		Tonsillitis		Chemotherapy	
Tobacco Habit		Kidney Disease		Tuberculosis		Circulatory Problems	
Chemical Dependancy		Liver Disease		Ulcer/s		Cortisone Treatments	
HIV/AIDS		Mitral Valve Prolapse		Venereal Disease		Cough (Persistent)	
Pacemaker		Pneumonia		Radiation Treatment		Respiratory Disease	
Epilepsy/ Seizures		Hepatitis Type____		Autism		Depression/Anxiety	
Diabetes Type 1/ Type 2		Other:_____		Other:_____		Other:_____	

Do you:

Smoke **Yes**___ **No**___ **Years**___	Chew Tobacco **Yes**___ **No**___ **Years**___	Pipes/Cigars **Yes**___ **No**___ **Years**___
Drink Alcohol **Yes**___ **No** ___**A Week** ___	Drink tap/city water **Yes**___ **No**___	Snack 4/more times per day **Yes**___ **No**___

Do you currently have any problems/or use any products listed below (mark all that apply)?

Swelling		Bad Taste		Bleeding Gums		Loose Teeth	
Sensitive to hot		Sensitive to cold		Sensitive to sweets		Sensitive to biting/pressure	
Prescription Toothpaste		Xylitol Products		Chlorohexidine		Other fluoride products	

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors that I may have made in the completion of this form. The signature below gives consent for the dentist at Hintz Family Dentistry, PC to perform dental procedures.

Signature of patient: _____ **Date:** _____

Signature of Parent/Guardian if patient is a minor: _____