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: _____

Do you have any Heart Conditions? **Yes**___ **No** ___ Have you had Head or Neck Radiation? **Yes**___ **No** ___

Are you currently taking any blood thinners? **Yes**___ **No** ___

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:

Biphosphonate Use		Cancer		Asthma		Liver Disease	
High Blood Pressure		Hemophilia		HIV/AIDS		Hepatitis Type____	
Artificial Joints		Autism		Stroke		Epilepsy/ Seizures	
Diabetes Type 1/ Type 2		Ulcer/s		Other:_____		Other:_____	

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: _____