Global Smiles, Inc
Lilliana Stojic, DDS, MAGD, FICOI, LLSR
1801 Professional Drive, Sacramento, CA 95825
916-487-5147

MEDICAL & DENTAL HISTORY

Patient Name: _____ Preferred Name: _____
Email: _____ Phone: _____

1. Are you currently under the care of a physician? ◯Yes ◯No Physician's Name: _____
   If yes, please explain: _____
2. Are you taking any prescription or over the counter drugs? ◯Yes ◯No
   If yes, please list each one: _____
3. Do you bleed excessively when injured? ◯Yes ◯No
4. **For Women**: Are you pregnant? ◯Yes ◯No Are you nursing? ◯Yes ◯No
   Are you currently taking birth control? ◯Yes ◯No
5. Please (check☑) either Yes or No for all conditions below that you have or have not had:

◯Yes ◯No AIDS/HIV+	◯Yes ◯No *Pre-Med	◯Yes ◯No High Blood Pressure
◯Yes ◯No Arthritis	◯Yes ◯No Pacemaker	◯Yes ◯No Sinus Problems
◯Yes ◯No Asthma	◯Yes ◯No Liver Disease	◯Yes ◯No Seizures
◯Yes ◯No Stroke	◯Yes ◯No Cancer	◯Yes ◯No Kidney Problems
◯Yes ◯No Vertigo	◯Yes ◯No Diabetes	◯Yes ◯No Low Blood Pressure
◯Yes ◯No Tuberculosis	◯Yes ◯No Hepatitis A/B/C	◯Yes ◯No Rheumatic Fever
◯Yes ◯No Heart Problem	◯Yes ◯No Epilepsy	◯Yes ◯No Other

6. If you (checked☑) YES to Heart Problem or Other, please explain_____
   _____
7. Please (check☑) either Yes or No for all of the items listed below that you may or may not be allergic to:

◯Yes ◯No Aspirin	◯Yes ◯No Penicillin	◯Yes ◯No Sulfa
◯Yes ◯No Erythromycin	◯Yes ◯No Tetracycline	◯Yes ◯No Dental Anesthetic
◯Yes ◯No Codeine	◯Yes ◯No Latex Gloves	◯Yes ◯No Acetaminophen
◯Yes ◯No Metals (Jewelry)	◯Yes ◯No Ibuprofen	◯Yes ◯No Other

8. Please list any other allergies:_____
9. What was your previous dentist's name?_____Date of last visit?_____
10. Have you ever had Periodontal corrections; for example: Gum surgery/ Root Planing/ Deep Cleaning. ◯Yes ◯No.
11. Have you ever had Orthodontic appliances/ Braces/ etc.? ◯Yes ◯No.
12. Do your gums bleed after brushing or flossing? ◯Yes ◯No
13. Do you smoke or chew tobacco? ◯Yes ◯No If yes, how much and/or often?_____
14. Have you ever taken medication for Osteoporosis? ◯Yes ◯No If yes, what?_____
15. Have you had any type of implant placed or joint replacement ◯Yes ◯No If yes, what? _____

TREATMENT CONSENT

The answers that I have provided are true to the best of my knowledge. In addition, I authorize the doctors and staff of Global Smiles to provide me with routine dental care including but not limited to radiographs, photographs, diagnostic, prophylactic, preventative and restorative dental procedures.

X_____Date _____

Signature of Patient (or Guardian if the patient is under 18 years of age)

Doctor's Signature: _____ Date _____