# Nampa Smiles Sedation & Family Dentistry

*Dr. Kim B. Keller, DDS*   *Dr. Amelia J. Justin, DMD*   *Dr. Scott Carter, DMD*   Date:______________________

**Patient Name**:_________________________________________ Email:____________________________________

Gender: M F Marital Status:______ Birth Date ___/___/___ Social Security #____-____-____

Home Phone____________________Work Phone____________________Cell Phone____________________

Address______________________________________________City_____________State_______Zip___________

Emergency Contact_________________________Phone #_____________________Relationship_______________

**Health Information** (please circle all those that apply past or present)

| | | | |
|---|---|---|---|
| AIDS/HIV positive | Drug Abuse | Liver Disease | Tobacco use: |
| Alzheimer's | Endocarditis | Metal Allergy | frequency_________ |
| Anemia | Epilepsy | Nervous Disorder | **Allergies:** |
| Arthritis | Epinephrine Reaction | Osteoporosis Meds | Latex |
| Artificial Joints | Excessive Bleeding | Pacemaker | Metal |
| date:___________ | Glaucoma | Pregnant? Due:_____ | Penicillin |
| Artificial Heart Valve | Head Injuries | Radiation Treatment | Codeine |
| Asthma | Heart Attack/Disease | Respiratory Problem | **List other drug** |
| Blood Disease | date:_________ | Rheumatic Fever | **allergies**:__________ |
| Blood Thinners | Heart Murmur | Sinus Problems | ____________________ |
| Blood Transfusion | Hepatitis A B C | Stroke | ____________________ |
| Cancer | High Blood Pressure | date:___________ | ____________________ |
| Diabetes | Hypoglycemic | Thyroid Disorder | ____________________ |
| Dizziness | Kidney Disease | Tuberculosis | ____________________ |
| | Latex Allergy | Tumors | ____________________ |

******Initial if you have NONE of the above: __________***

**Please list medications you are currently taking**:_______________________________________________________

_____________________________________________________________________________________________

**Do you need to take antibiotics before dental cleanings?** ___Yes ___No
If yes, which antibiotic do you take? _______________________________

**Do you have any other health problems that need further clarification?** ____yes____no
If yes, please explain:__________________________________________________________________________

_____________________________________________________________________________________________

**How do you rate your fear of dental treatment:** ____Excessive ____Moderate ____Low

*To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appo*

| | | |
|---|---|---|
| _____ __/__/__ | _____ __/__/__ | _____ __/__/__ |
| _____ __/__/__ | _____ __/__/__ | _____ __/__/__ |

__________________________________________date __/__/__
*Signature of patient, parent, or guardian*

**Whom may we thank for referring you to our practice?** ___Another patient – friend ___Another patient – relative
___Dental office ___Yellow Pages __Newspaper ___School ___Work ___Other:___________________________

**Name of person or office referring you to our practice, if applicable:**_________________________________