Urban Smiles Dental
776 E. 3rd Avenue * Roselle, NJ 07203
(908) 245-1600

HAVE YOU EVER HAD, BEEN TREATED FOR, OR TOLD YOU'VE HAD:

(PLEASE CHECK)

YES	NO	
☐	☐	BLOOD DISEASES
☐	☐	FREQUENT INFECTION
☐	☐	EXCESS BLEEDING FOLLOWING A SCRATCH OR CUT
☐	☐	JOINT PROSTHESIS OR ARTIFICIALHIP
☐	☐	HEART DISEASE
☐	☐	PAIN OR PRESSURE IN CHEST / ANGINA
☐	☐	RHEUMATIC FEVER
☐	☐	HEART MURMUR
☐	☐	MITRAL VALVE PROLAPSE
☐	☐	STROKE
☐	☐	HIGH OR LOW BLOOD PRESSURE
☐	☐	SHORTNESS OF BREATH
☐	☐	DIABETES
☐	☐	DRY OR BURNING MOUTH
☐	☐	STOMACH OR INTESTINAL TROUBLE
☐	☐	LIVER OR GALL BLADDER DISEASE
☐	☐	HEPATITIS OR JAUNDICE
☐	☐	GLAUCOMA
☐	☐	FACIAL INJURIES OR TOOTHACHES
☐	☐	KIDNEY DISEASE
☐	☐	BACK PAIN

YES	NO	
☐	☐	GONORRHEA / SYPHILIS / HERPES
☐	☐	TUBERCULOSIS
☐	☐	HAVE YOU BEEN TESTED FOR H.I.V.
☐	☐	OTHER INFECTIONS DISEASE
☐	☐	NERVOUS OR MENTAL DISORDER
☐	☐	EPILEPSY, SEISURES, CONVULSIONS, OR FAINTING
☐	☐	RESPIRATORY DISEASE
☐	☐	ASTHMA
☐	☐	BRONCHITIS OR EMPHYSEMA
☐	☐	DIFFICULTY IN BREATHING
☐	☐	TUMORS, GROWTHS, CYSTS, OR CANCER
☐	☐	HAVE YOU HAD RADIATION OR CHEMO-THERAPY?
☐	☐	MAJOR OPERATIONS OR HOSPITALIZATIONS
☐	☐	HAVE YOU RECEIVED ANY BLOOD TRANSFUSIONS?
☐	☐	DO YOU SMOKE OR USE CHEWING TOBACCO?
☐	☐	ALCOHOL USE
☐	☐	DRUG USE
☐	☐	REACTION TO PENICILLIN OR OTHER MEDICATIONS
☐	☐	DO YOU HAVE ANY ALLERGIES?
☐	☐	IS THERE ANYTHING THAT YOU WISH TO DISCUSS WITH THE DOCTOR IN PRIVATE?
☐	☐	ARE YOU IN GOOD HEALTH?

FEMALES, PLEASE COMPLETE THE FOLLOWING:

YES	NO	
☐	☐	ARE YOU PREGNANT?
☐	☐	ARE YOU TAKING BIRTH CONTROL MEDICATION OR PILLS?

CONSENT FOR TREATMENT

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, HAVE COMPLETED THE ABOVE TO THE BEST OF MY KNOWLEDGE. I CONSENT TO THE PERFORMING OF WHATEVER PROCEDURE(S) MAY BE DECIDED UPON TO BE NECESSARY OR ADVISABLE. I ALSO CONSENT TO THE USE OF LOCAL ANESTHETICS AND/OR INHALATION SEDATIVES WHERE INDICATED. I AUTHORIZE THE USE OF MY SIGNATURE FOR INSURANCE CLAIM SUBMISSION/ ASSIGNMENT ON MY BEHALF.

IF THIS OFFICE IS ABLE TO ACCEPT YOUR INSUREANCE COMPANY'S ADDIGNMENT, THE PATIENT IS STILL FULLY RESPONSIBLE FOR THE CHARGES FOR THE TREATMENT RENDERED. YOUR INSURANCE MAY NOT COVER THE SERVICES OT MAY ONLY PARTIALLY COVER THEM AND ANY ESTIMATE GIVEN BY THIS OFFICE IS CONSIDERED A GUIDELINE UNTIL THE FINAL INSURANCE IS RECEIVED AND THE PATIENT'S ACCOUNT IS RECONCILED. THE OFFICE CAN MAKE NO GUARANTEE OF THE ACTUAL PAYMENT BY YOUR INSURANCE COMPANY.

SIGNATURE X____________________ DATE ____________________
(PARENT OR GUARDIAN IF PATIENT IS UNDER AGE OF 18)

MEDICAL HISTORY