PATIENTS DENTAL HEALTH

Name: _____ **Date:** _____

Previous Dentist: _____ **Last Visit:** _____ **Date of last cleaning:** _____

SMILE EVALUATION

Our goal is to provide you with the best dental treatment possible. Below are a few questions to help us better meet your dental needs.

If you could change one thing about your smile, what would it be?: _____

Do you grind or clench your teeth? **Yes:** _____ **No:** _____

If so, does your jaw hurt or give you headaches? **Yes:** _____ **No:** _____

Are you missing any teeth? **Yes:** _____ **No:** _____

If so, how long have they been missing? _____

Are you interested in dental implants to replace missing teeth? _____

Are you interested in Sedation Dentistry? **Yes:** _____ **No:** _____

Would you like your teeth to be straightened? **Yes:** _____ **No:** _____

If so, are you intrested in Invisalign? _____ **Braces?** _____

PATIENT MEDICAL HISTORY

I consider my health to be *(please check one)*: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you or have you had any of the following? *(circle Y for yes or N for no)*

1. ☐Y ☐N Heart Disease
2. ☐Y ☐N Heart Murmur/Mitral Valve Prolapse
3. ☐Y ☐N Stroke
4. ☐Y ☐N Congenital Heart Lesions
5. ☐Y ☐N Abnormal Blood Pressure
6. ☐Y ☐N Anemia
7. ☐Y ☐N Prolonged Bleeding Disorder
8. ☐Y ☐N Rheumatic Fever
9. ☐Y ☐N Tuberculosis or Lung Disease
10. ☐Y ☐N Asthma
11. ☐Y ☐N Swollen Ankles
12. ☐Y ☐N Emphysema
13. ☐Y ☐N Hay Fever
14. ☐Y ☐N Sinus Trouble
15. ☐Y ☐N Epilepsy/Seizures
16. ☐Y ☐N Ulcers
17. ☐Y ☐N Implants/Artificial Joints. ☐Hip ☐Knee ☐Other _____
18. ☐Y ☐N I smoke or use tobacco. If yes, how much per day? _____ How many years? _____
19. ☐Y ☐N I have consumed alcohol within the past 24 hours.
20. ☐Y ☐N I usually take an antibiotic prior to dental treatment.
21. ☐Y ☐N Have you ever taken Fen-Phen or Redux?
22. ☐Y ☐N I have had major surgery. Year: _____ Type of operation: _____
23. ☐Y ☐N Liver Disease
24. ☐Y ☐N Jaundice
25. ☐Y ☐N Hepititis: Type:
26. ☐Y ☐N Diabetes
27. ☐Y ☐N Excessive Urination and/or Thirst
28. ☐Y ☐N Infectious Mononucleosis (Mono)
29. ☐Y ☐N Herpes
30. ☐Y ☐N Arthritis
31. ☐Y ☐N Sexually Transmitted/Venereal Disease
32. ☐Y ☐N Kidney Disease
33. ☐Y ☐N Tumor or Malignacy
34. ☐Y ☐N Cancer/Chemotherapy
35. ☐Y ☐N Radiation Treatment
36. ☐Y ☐N History of Drug Addiction
37. ☐Y ☐N AIDS or HIV Infection

DOCTORS NOTES ONLY:

38. ☐Y ☐N Immune Suppressed Disorder
39. ☐Y ☐N Hearing Loss
40. ☐Y ☐N Fainting Spells
41. ☐Y ☐N Glaucoma
42. ☐Y ☐N History of Emotional/Nervous Disorder

WOMEN

43. ☐Y ☐N Are you taking birth control medication?
44. ☐Y ☐N Are you or could you be pregnant or nursing?
45. ☐Y ☐N Do you have any other medical problem or medical history NOT listed on this form?

_____
_____
_____
_____

Are you allergic to any of the following? *(circle Y for yes or N for no)*

46. ☐Y ☐N Aspirin
47. ☐Y ☐N Ibuprofen
48. ☐Y ☐N Sulfa Drugs/Sulfates/Sulfides
49. ☐Y ☐N Penicillin
50. ☐Y ☐N Codeine
51. ☐Y ☐N Latex, Metals, Plastics
52. ☐Y ☐N Local Anesthetics (Novacaine)
53. ☐Y ☐N Barbituates

Please list all medications you are currently taking in the lines provided.

54. ☐Y ☐N Sedatives
55. ☐Y ☐N Other medications - which ones? _____

Medicine: _____ Condition: _____
Medicine: _____ Condition: _____
Medicine: _____ Condition: _____

Physician's Name: _____
Phone: _____ Fax: _____
Addresss: _____ City: _____ State: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PATIENT SIGNATURE
x _____ Date: _____

GUARDIAN SIGNATURE
x _____ Date: _____

DOCTOR INITIAL EXAM
x _____ Date: _____

DOCTOR PERIODIC EXAM
x _____ Date: _____