



COMPLETE SMILE

Patient Name _____

MEDICAL HISTORY

Do you have a personal physician? _____

Are you currently under a physician's care? _____

Physician's Name _____ Physician's Phone # _____

YOUR CURRENT PHYSICAL HEALTH IS:

GOOD _____ FAIR _____ POOR _____

Do you smoke or use tobacco in any form? Yes ___ No ___

Do you have any implant , valves, rod or pins? Yes ___ No ___

Are you taking any medication? Yes ___ No ___

Please List: _____

FOR WOMEN:

Are you taking birth control pills? Yes ___ No ___

Are you pregnant? Yes ___ No ___ Week#: _____

Are you nursing ? Yes ___ No ___

Have you ever had any of the following diseases or Medical

Problems: (Please check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Alcohol/ drug abus | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Kidnry Problems | <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Cancer/Chemo | <input type="checkbox"/> Mitral Valve Prolepses | <input type="checkbox"/> Congenital Heart Deffect |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Fainting/Dizzy Spells | <input type="checkbox"/> Shingles | <input type="checkbox"/> Sickle Cell Trait/Disease |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Artificial Joints/Valves | <input type="checkbox"/> Herpes |

Please list any serious medical condition(s) that are not listed above:

Are you allergic to any of the following? (Please Check)

- | | | | | |
|-------------------------------------|---------------------------------------|---------------------------------|---|---------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals | <input type="checkbox"/> Dental Anesthetics | Codeine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline | |

Questions or concerns?



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DENTAL HISTORY

What is the primary reason for your visit today?

Are you currently in pain? Yes__ No__

Do you require antibiotics before dental treatment? Yes__ No__

YOUR CURRENT DENTAL HISTORY IS:

GOOD____ FAIR____ POOR____

When was the last time you had a complete dental evaluation?_____

Have you ever had a serious/difficult problem associated with any previous dental work? Yes__ No__

Do you floss regularly? Yes__ No__

Brush Daily? Yes__ No__

Have you ever been informed or treated for the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Osseous Surgery | <input type="checkbox"/> Mobility of Teeth |
| <input type="checkbox"/> Bad Taste / Odor | <input type="checkbox"/> Cold Sores / Ulcers | <input type="checkbox"/> Deep Cleaning / Scaling |
| <input type="checkbox"/> Wisdom Teeth Extract | <input type="checkbox"/> TMI /TMD Join Pain | <input type="checkbox"/> Gum/Periodontal Disease |
| <input type="checkbox"/> Oral Cancer / Biopsy | <input type="checkbox"/> Hot/Cold Sensitivity | <input type="checkbox"/> Toothbrush Abrasion |

Would you like fresher breath? Yes__ No__

Would you like whiter teeth? Yes__ No__

Are you happy with how your smile looks? Yes__ No__

If not, what would you change?_____

WORK AUTHORIZATION & FINANCIAL POLICY

The undersigned hereby authorizes the Doctor to take x-rays, study, models photographs or any other diagnostics aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies certain risks. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a Finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. We respect that your time is valuable, please respect ours also, therefore, if appointments are continuously cancelled or charged without a 48hr notice; we require a reservations fee for future appointments.

Please list any other drugs/materials that you are allergic to:

Patient's (Parent) Signature _____

Date _____

Dentist Initials _____