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)

☐ Alcohol/Drug Abuse	☐ Anemia	☐ Hepatitis	☐ Arthritis
☐ High Blood Pressure	☐ Ulcers	☐ HIV / AIDS	☐ Asthma
☐ Kidney Problems	☐ Bleeding Problems	☐ Liver Disease	☐ Blood Transfusion
☐ Low Blood Pressure	☐ Cancer/Chemo	☐ Mitral Valve Prolapse	☐ Congenital Heart Deffect
☐ Pacemaker	☐ Diabetes	☐ Psychiatric Problems	☐ Difficulty Breathing
☐ Heart Murmur	☐ Emphysema	☐ Rheumatic Fever	☐ Epilepsy
☐ Seizures	☐ Fainting/Dizzy Spells	☐ Shingles	☐ Sickle Cell Trait/Disease
☐ Migraines	☐ Heart Attack	☐ Sinus Problems	☐ Radiation Treatment
☐ Stroke	☐ Hemophilia	☐ Artificial Joints/Valves	☐ Herpes

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

_____

_____

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

☐ Aspirin	☐ Erythromycin	☐ Metals	☐ Dental Anesthetics	☐ Codeine
☐ Penicillin	☐ Jewelry	☐ Latex	☐ Tetracycline	☐ Sulfa

Questions or concerns?

_____

_____

COMPLETE SMILE

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?

☐ Bleeding Gums	☐ Osseous Surgery	☐ Mobility of Teeth
☐ Bad Taste / Odor	☐ Cold Sores / Ulcers	☐ Deep Cleaning / Scaling
☐ Wisdom Teeth Extract	☐ TMI /TMD Join Pain	☐ Gum/Periodontal Disease
☐ Oral Cancer / Biopsy	☐ Hot/Cold Sensitivity	☐ 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 _____