Art of Smiles

Health History

Today's date: _____

Name: Last First MI Preferred Name

_____

Phone: Home: (____) _____ Cell: (____) _____ Work: (____) _____

Best way to contact you: ☐ Email ☐ Text message ☐ Phone

Address: _____ City: _____ State: ____ Zip: _____

Occupation: _____ Email: _____

Date of Birth: _____ Sex: ☐ M ☐ F SS#: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: Home: (____) _____ Cell: (____) _____

If you are completing this form for another person, what is your relationship to that person?

Your Name: _____ Relationship: _____

Dental Information

Please mark an (x) to your responses to the following questions:

What is the reason for your dental visit today? _____

	Yes	No
Is your mouth dry?	☐	☐
Have you had periodontal (gum) treatments?	☐	☐
Have you had trouble getting or staying numb in the past?	☐	☐
Do you gag easily during dental work?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you have bad breath?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you have clicking, popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental visit: _____

What was done at that time? _____

How often do you floss? _____ brush? _____

Have you had any problems associated with previous dental treatment?

☐ Yes ☐ No Explain: _____

_____

Are you fearful of dentistry? ☐ Yes ☐ No

If you are fearful of dentistry and would like to be sedated (sleeping) for dental work, what makes you nervous?

Check all that apply, so the doctor can discuss with you:

☐ Needles ☐ Cleanings ☐ Drilling Sounds ☐ Smells
☐ Anticipation of pain ☐ Gagging ☐ Surgery ☐ Everything!

Smile Evaluation

Please mark an (x) to your responses to the following questions:

With recent advancements in materials and techniques, many of our patients are asking questions about advanced dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

	Yes	No
Do you like the appearance of your teeth?	☐	☐
Are your teeth as straight as you would like them to be?	☐	☐
Are your teeth as white as they could be?	☐	☐
Do you have spaces between your teeth?	☐	☐
Do you have any dental work that you do not like?	☐	☐
Do you have any mercury silver fillings that you would like changed to white?	☐	☐
Has anyone you have known had any cosmetic or implant dentistry done that interests you?	☐	☐

If you could change anything about your mouth, teeth or smile, what would it be?

_____

_____

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Health History

Medical Information

Please mark an (x) to your responses to the following questions:

	Yes	No
Are you in good health?	☐	☐
Are you under the care of a physician?	☐	☐

Physicians Name: _____

Phone (w/area code): _____

Address/City/State/Zip: _____

	Yes	No
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

Date of last medical exam: _____

If yes, what was the illness or problem:

_____

Please mark an (x) to indicate if you have or have not had any of the following diseases or problems:

	Yes	No
01. Heart murmur	☐	☐
02. Mitral valve prolapse	☐	☐
03. Artificial heart valves	☐	☐
04. Rheumatic fever/ disease	☐	☐
05. Cardiovascular disease	☐	☐
06. Angina (Chest Pain)	☐	☐
07. Arteriosclerosis (hardening of the arteries)	☐	☐
08. Congestive heart failure	☐	☐
09. Coronary artery disease	☐	☐
10. Damaged heart valves	☐	☐
11. Heart attack	☐	☐
12. Low blood pressure	☐	☐
13. High blood pressure	☐	☐
14. Congenital heart defects	☐	☐
15. Pacemaker	☐	☐
16. Taking blood thinner	☐	☐
17. Abnormal bleeding	☐	☐
18. High cholesterol	☐	☐
19. Anemia	☐	☐
20. Blood disease	☐	☐
21. AIDS or HIV	☐	☐
22. Arthritis	☐	☐
23. Autoimmune Disease	☐	☐
24. Rheumatoid arthritis	☐	☐
25. Lupus	☐	☐
26. Asthma	☐	☐
27. Emphysema or Lung Disease	☐	☐
28. Sinus trouble	☐	☐
29. Tuberculosis	☐	☐
30. Cancer	☐	☐
31. Chemotherapy	☐	☐
32. Radiation treatment	☐	☐
33. Bruise easily	☐	☐
34. Diabetes Type I or II	☐	☐
35. Depression	☐	☐
36. Gastrointestinal Disease	☐	☐
37. Reflux/persistent heartburn/GERD	☐	☐
38. Ulcers	☐	☐
39. Thyroid problems	☐	☐
40. Stroke	☐	☐
41. Glaucoma	☐	☐
42. Hepatitis, or liver disease Type A, B C	☐	☐
43. Epilepsy or seizures	☐	☐
44. Fainting spells	☐	☐
45. Sleep apnea	☐	☐
46. Kidney problems	☐	☐
47. Osteoporosis	☐	☐
48. Alcoholism	☐	☐
49. Excessive headaches /migraines	☐	☐
50. Sexually transmitted Disease	☐	☐
51. Chemical dependency	☐	☐
52. Steroid treatment (ex. Prednisone)	☐	☐
53. Facial cosmetic surgery	☐	☐
54. Anxiety	☐	☐
55. Mental health disorders	☐	☐

Specify:

_____

	Yes	No
56. Neurological disorders	☐	☐

If yes, specify:

_____

Are you taking any of these medications?	Yes	No
Antacids	☐	☐
St. John's Wort or Kava-Kava?	☐	☐
Dilantin® or Tegretol®	☐	☐
Barbiturates (any)	☐	☐
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®, RECLAST) or PROLIA? If so, when did the treatment begin?	☐	☐

When did the treatment end? _____

Have you ever taken any prescription drugs such as fen-phen for weight loss?	☐	☐
Do you consume grapefruit juice, grapefruits or grapefruit extract?	☐	☐

Please list any medications you are currently taking and dosages or provide a list please:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Are you allergic or have you had a reaction to:	Yes	No
a. Local anesthetics or epinephrine	☐	☐
b. Penicillin or other antibiotics	☐	☐
c. Aspirin, Ibuprofen or Tylenol	☐	☐
d. Codeine, Valium, Hydrocodone, Oxycodone or other sedatives	☐	☐
e. Latex or Metals	☐	☐
f. Other (please specify): _____		

Weight and Diet considerations: Weight: _____ Meals per Day: _____

Dietary Restrictions:

1. _____ 3. _____
2. _____ 4. _____

Sugar in your diet (select one): ☐none ☐slight ☐moderate ☐high

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐No

Do you have any disease, condition, or problem not listed on this form?
☐Yes ☐No Please explain: _____

	Yes	No
Do you use any recreational drugs (such as marijuana)?	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐
If so, how interested are you in stopping? Check one: ☐Very ☐Somewhat ☐Not Interested		
Do you drink alcoholic beverages?	☐	☐

If yes, how much do you typically drink in a week? _____

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 3. _____
2. _____ 4. _____

WOMEN ONLY

	Yes	No
Are you pregnant?		
Number of weeks: _____		
Taking birth control pills or hormonal replacement?	☐	☐
Are you nursing?	☐	☐
Anticipating becoming pregnant?	☐	☐

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history: _____

_____

_____

_____

Significant findings from questionnaire or oral interview: _____

_____

_____

_____

Dental management considerations: _____

_____

_____

_____

I hereby certify that I have read and understand the previous information and that it is accurate and true. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office before my next appointment without fail.

I have not made any errors or omissions to my medical and dental history.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I also authorize a dental cleaning if that is recommended.

I understand that I may need to be prescribed medication to treat my dental condition and anesthetics may need to be administered. I understand that antibiotics, analgesics, anesthetics and other medications commonly used in dentistry can cause allergic reactions, temporary or permanent numbness, and/or anaphylactic shock.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. If I have insurance, I authorize the payment from my insurance carrier to submit directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided. I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services on my behalf or on behalf of my dependents (if any).

Signature of Patient/Legal Guardian	Date	Relationship
_____	_____	_____

Signature of Dentist	Date
_____	_____