



Welcome! In order to provide you with the best possible care please complete both sides of this medical/dental history form. All information will be kept confidential.

Medical history section with fields for Date of your last physical exam, Physician's name, Phone, Address, Medical Specialist name, Phone, Address.

- Have you ever been hospitalized for any surgical operation(s) or serious illness(es)? Y N Have you ever required a blood transfusion? Y N
o Please explain
o Date of the visit(s)

Medications section: Are you taking any medications including nonprescription medications? If yes please specify. Fields for Name, Dose, Name, Dose, Name, Dose, Name, Dose.

- If you need additional room please use the bottom of the page.
Do you or have you used controlled/ recreational drugs? Y N Please specify
Do you use Tobacco? Cigarettes? Chewing tobacco? Y N
Have you lost or gained more than 10 pounds last year? Y N
Have you ever taken Fen-Phen or Redux? Y N for how long Have you seen a Cardiologist for a medical exam for Heart issues after? Y N
Have you ever had bisphosphonate drugs for Cancer or Osteoporosis? Y N For how long?
Women: Are you pregnant? Y N Month Due date Nursing? Y N
Taking birth control pills/ birth control patch/devices? Y N Specify?
Are you allergic to/have you had any serious reactions (Rash, Hives, shortness of breath) to:
o Local anesthetic like Novocain Y N Iodine or shellfish Y N
o Penicillin or other antibiotics specify Y N Any metals? Specify Y N
o Sulfa drugs Y N Latex/ Rubber Y N
o Barbiturates, sedatives or sleeping pills Y N Other medications
o Aspirin or similar NSAID's Y N
Are you wearing contact lenses? Y N

Do you have or have you had the following: (please circle all that apply and elaborate if needed, additional room provided at the end of the form)

Table with two columns of medical conditions and Y/N response options. Includes: Heart defect/murmur, Artificial heart valve, Mitral valve prolapse, Rheumatic heart disease or rheumatic fever, Heart surgery, trouble, attack or angina, Pacemaker, Chest pain, shortness or breath, High/Low blood pressure, High Cholesterol? LDL?, Stroke, Glaucoma, Lung or breathing problems, Emphysema, Tuberculosis, persistent or bloody cough, Asthma / Hay fever, Environmental Allergies? specify, Sinus trouble, Hives/skin rash/other skin conditions, Cold sores/Fever treatment, Stomach ulcer, reflux, IBS, Crohn's disease, Kidney trouble, Hepatitis A B C : Date(s)?, Jaundice, Anemia or blood disorders? Specify, Hemophilia, Tumor(s) or cancer(s), Chemotherapy for Cancer or Leukemia, Radiation therapy? For how long Dosage, Diabetes. Do you have to use Insulin?, Hypoglycemia, Thyroid problems, AIDS or HIV infection, Sexually transmitted disease? Specify, Chemical dependency, addictions, Please specify. Alcohol? Other?, Eating disorders- Bulimia? Anorexia?, Special restricted diet, Steroid / Cortisone treatment, When How much was given For how long, Arthritis, rheumatism, fibromyalgia, MS, Back problems, Swollen ankles, Joint replacement or implant, When was it done? Which Joint? Knee, hip, shoulder, Neurologic disorders, Epilepsy or seizures, Chronic pain condition, Nervousness or phobias, Head or neck trauma, whiplash, Fainting or dizzy spells, Vertigo?, Mental health care. Diagnosis, Scarlet fever.

Do you have any disease, condition or problem not listed above that you think I should know about? Please explain
Additional comments(from above)

Name(print): Signature:(parent/Guardian must sign for a minor):
Date:



Patient information
Name, ID/SSN#, Birthdate, Age, Address, City, State, ZIP, Employer, Occupation, Business address, Business phone, e-mail, Whom may we thank for referring you?, In case of emergency who should be notified? Phone

Dental History
Reason for this visit, Date of last dental visit, Previous dentist name/location, Date of last complete series of x-rays, How often do you brush your teeth?, How often do you floss?, Circle all that you are concerned about/currently have (L-left, R-right, T-top, B-bottom)
Tooth pain/ache, Cavities, Broken teeth, Dark teeth, Sensitivity to hot cold sweets, Spacing, Broken fillings, Bleeding gums, Missing teeth, Loose teeth, Want whiter teeth, Ugly teeth, Crooked teeth, Snoring/Apnea, Headaches, Bad breath

Do you frequently get cold sores, blisters or any other lesions?
Have you ever had (check all that apply): Orthodontic treatment, Oral surgery (tooth extractions), Your teeth ground or the bite adjusted, A bite plate or mouth guard, A serious injury to the mouth, Periodontal treatment (including gum surgeries)
Have you experienced (check all that apply): Clicking or popping of the jaw, Pain? Joint, ear, side of face, Difficulty in chewing on either side of the mouth, Headaches, neck aches or shoulder aches, Sore muscles (neck, shoulder), Difficulty in opening or closing the mouth
I am changing dentists because (check all that apply): Recently moved into this area from, Dr/Staff personality/ communication problem, Fee concern, Want a dentist team who understands my needs, Inadequate care

How did you first hear about us? Convenient location (Sign on the road), Family member already comes here, Referred by a friend, Received your Card in the mail, Saw your internet web site, Other
I have avoided dental care in the past because: Fear of, Time commitment, Financial commitment, Trust factor
If you could change anything about your smile, what would you change?
Are you interested in exploring (check all that apply): Dental wellness (going beyond good health), Ways to reduce or eliminate periodontal surgery, Smile makeover/enhancement, Why dental infections cause heart and other disease, Office whitening or home whitening

Do you feel nervous about having dental treatment? If so what is your biggest concern?
Have you ever had an upsetting dental experience or have heard anything negative about dentistry? If yes please describe

The Emotional Smile Evaluation

The emotional smile evaluation is based on each individual's subjective perceptions of his or her smile. The questions below are designed to help reveal a person's inner feelings about how their smile affects their self image, how it impacts interactions with others, and how it influences the quality of their relationships.

Do you like the appearance of your teeth and smile? Y N

Do you ever turn your face when smiling or hold your hand up in front of your mouth when talking to others? Y N

Have you ever found yourself looking at models or other people with beautiful smiles and wishing you had a similar smile? Y N

Have you figured out a way to use your lips to cover any aspect of your smile? Y N

Are you embarrassed to visit a dentist knowledgeable and focused on cosmetics due to the condition of your teeth or the length of time since your last visit to a dentist? Y N

How does your smile make you feel? Confident? Y N

Do you shy away from showing a full smile in front of other people, especially strangers? Y N

When taking pictures, do you tend to smile with your lips closed instead of flashing a happy smile? Y N

Have you ever held back a laugh because you felt uncomfortable about your smile? Y N

How would a beautiful new smile make you feel?

Authorization: I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.