



# Smile Dental Associates, PC

## MEDICAL HISTORY

Do you have a personal physician?    \_\_\_yes    \_\_\_no

Physician's Name: \_\_\_\_\_ Physician's phone: \_\_\_\_\_

Date of last medical visit: \_\_\_\_\_

Your current medical health is:    \_\_\_good    \_\_\_fair    \_\_\_poor

Are you currently under the care of a physician?    \_\_\_yes    \_\_\_no

Please explain: \_\_\_\_\_

Do you use tobacco in any form?    \_\_\_yes    \_\_\_no

Have you has any metal rods, pins, or implants placed?    \_\_\_yes    \_\_\_no

Are you taking any medications, prescription or herbal?    \_\_\_yes    \_\_\_no

Please list each one: \_\_\_\_\_

Have you ever had any surgical procedures?    \_\_\_yes    \_\_\_no

Please list each one: \_\_\_\_\_

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
0	0	Abnormal Bleeding	0	0	Glaucoma	0	0	Stroke
0	0	Alcohol Abuse	0	0	HIV or AIDS	0	0	Thyroid Problem
0	0	Allergies	0	0	Heart Attack	0	0	Tuberculosis
0	0	Anemia	0	0	Heart Murmur	0	0	Ulcers
0	0	Angina Pectoris	0	0	Heart Surgery	Yes No Allergies <input type="checkbox"/> <input type="checkbox"/> Aspirin <input type="checkbox"/> <input type="checkbox"/> Codeine <input type="checkbox"/> <input type="checkbox"/> Dental Anesthetics <input type="checkbox"/> <input type="checkbox"/> Erythromycin <input type="checkbox"/> <input type="checkbox"/> Jewelry <input type="checkbox"/> <input type="checkbox"/> Latex <input type="checkbox"/> <input type="checkbox"/> Metals <input type="checkbox"/> <input type="checkbox"/> Penicillin <input type="checkbox"/> <input type="checkbox"/> Tetracycline other allergies _____		
0	0	Arthritis	0	0	Hemophilia			
0	0	Artificial Heart Valve	0	0	Hepatitis A, B, or C			
0	0	Asthma	0	0	High Blood Pressure			
0	0	Blood Transfusion	0	0	Joint Replacement			
0	0	Cancer	0	0	Kidney Problems			
0	0	Chemotherapy	0	0	Liver Disease			
0	0	Colitis	0	0	Low Blood Pressure			
0	0	Congenital Heart Defect	0	0	Mitral Valve Prolapse			
0	0	Diabetes	0	0	Pace Maker			
0	0	Difficulty Breathing	0	0	Psychiatric Problems	Yes No If Female, Please Answer <input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If so, # of Weeks _____ <input type="checkbox"/> <input type="checkbox"/> Are you nursing?		
0	0	Drug Abuse	0	0	Radiation Therapy			
0	0	Emphysema	0	0	Rheumatic Fever			
0	0	Epilepsy	0	0	Seizures			
0	0	Facial Surgery	0	0	Sexually Transmitted Diseases			
0	0	Fainting Spells	0	0	Shingles			
0	0	Fever Blisters	0	0	Sickle Cell Disease			
0	0	Frequent Headaches	0	0	Sinus Problems			

Nearest relative not living with you: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

# Smile Dental Associates,PC

## Dental History

How may we help you today? \_\_\_\_\_

Your current dental health is:     Good     Fair     Poor

Do you require antibiotics before dental treatment?     Yes     No    Why? \_\_\_\_\_

Are you currently in pain?     Yes     No

Have you ever had any periodontal (gum) treatments?     Yes     No    When? \_\_\_\_\_

Do your gums bleed?     Yes     No

Are you under stress? (i.e. new job, moving, relationships)     Yes     No

Do you like your smile?     Yes     No

Is there anything you would like to change about your smile?     Yes     No

Are you happy with the color of your teeth?     Yes     No

How many times do you: floss per week \_\_\_\_\_ brush per day \_\_\_\_\_

Are your teeth sensitive to hot, cold, biting, or anything else?     Yes     No    Specify: \_\_\_\_\_

Have you lost any adult teeth?     Yes     No

Have you ever had a serious or difficult problem with the previous dental work?     Yes     No

When was your last dental exam? \_\_\_\_\_ Cleaning? \_\_\_\_\_ Full set of x-rays (18) \_\_\_\_\_

When was your last dental visit for any treatment? \_\_\_\_\_

Why did you leave your previous dentist? \_\_\_\_\_

At Smile Dental Associates, PC we offer a wide variety of services to enhance your smile and keep it beautiful.

**Circle the services you would like discussed in more detail.**

Teeth Whitening (Britesmile, Zoom, NiteWhite)    Porcelain Veneers    Smile Makeover

Adult Orthodontics (Invisalign, PowerProx 6 month Braces)    Bonding

Sealants    Crowns and Bridges    Implants

Partial and Full dentures    Nightguards/Sportguards    Snore Appliances