

**Smile Magic Dentistry
Medical/Dental History**

MEDICAL HISTORY

1) How would you rate your overall health?..... GOOD FAIR POOR

2) Date of last physical examination: _____

3) Are you currently under the care of a physician?..... YES NO

If yes, for what condition(s)? _____

4) Physician information: _____

NAME	PHONE NUMBER
ADDRESS	CITY
STATE	ZIP

5) Have you had any serious illness, operations, or been hospitalized within the past 5 years?..... YES NO

If yes, for what reason? _____

6) Have you had any cosmetic procedures or elective surgeries completed?..... YES NO

If yes, please describe: _____

Please provide us with the following information of the physician in charge of the procedure:

NAME	PHONE NUMBER	ADDRESS	CITY	STATE	ZIP
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7) Have you had medical x-rays in the last 5 years? YES NO

If yes, please explain: _____

8) Are you taking any prescribed medications, over-the-counter medications, creams, supplements or herbs? If yes, **please list all**..... YES NO

	NAME	DOSE/FREQUENCY	REASON FOR TAKING
PRESCRIBED MEDICATIONS	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OVER THE COUNTER
MEDICATIONS _____

VITAMINS, NATURAL
OR HERBAL
PREPARATIONS,
DIET SUPPLEMENTS _____

9) Do you use tobacco products? YES NO
If yes, how interested are you in quitting? VERY SOMEWHAT NOT INTERSTED

10) Do you drink alcoholic beverages? YES NO
If yes, please list how many per week, e.g., 1-2 drinks/week: _____

11) Do you use recreational or street drugs? YES NO
If yes, how often? _____

12) Do you have any **allergies** (i.e., itching, rash, swelling of hands, eyes, or feet), or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, or medications?..... YES NO
If yes, please list what you are allergic to and your reaction: _____

13) When you walk up stairs or take a walk, do you ever have to stop because of chest pain?..... YES NO

14) Do your ankles swell during the day?..... YES NO

15) Do you use more than 2 pillows to sleep?..... YES NO

Patient's Name: _____

- 16) Do you wake up short of breath?..... YES NO
 - 17) Have you lost or gained more than 10 pounds in the last year? YES NO
 - 18) Are you on a special diet? YES NO
 - 19) Have you been told that you needed to be premedicated prior to any dental work?..... YES NO
- If yes, for what reason? _____

Check any of the following **cardiovascular/heart conditions** you currently have or have had in the past:

<input type="checkbox"/> Angina	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Artificial heart valves
<input type="checkbox"/> Chest pain upon exertion	<input type="checkbox"/> Congenital heart lesions/defects	<input type="checkbox"/> Congenital heart failure
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Damaged heart valves	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Heart surgery	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Heart pacemaker	<input type="checkbox"/> Rheumatic heart disease/Rheumatic fever	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Stroke	<input type="checkbox"/> Other (please specify): _____	
<input type="checkbox"/> NONE		

Check any of the following **respiratory conditions** you currently have or have had in the past:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Persistent cough or cough that produces blood	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Tuberculosis (TB)	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> NONE		

Check any of the following **blood disorders** you currently have or have had in the past:

<input type="checkbox"/> Abnormal bleeding	<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Bruise easily
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Leukemia	
<input type="checkbox"/> Sickle cell disease	<input type="checkbox"/> Other (please specify): _____		
<input type="checkbox"/> NONE			

Check any of the following **psychological conditions** you currently have or have had in the past:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Psychiatric treatment	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Other (please specify): _____			
<input type="checkbox"/> NONE			

Check any of the following **liver conditions** you currently have or have had in the past:

<input type="checkbox"/> Cirrhosis/liver disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Jaundice/yellow jaundice	<input type="checkbox"/> Other (please specify): _____
<input type="checkbox"/> NONE			

Check any of the following health conditions you currently have or have had in the past:

<input type="checkbox"/> Allergies or hives	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Artificial Joint	<input type="checkbox"/> Cancer
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Cold sores/fever blisters	<input type="checkbox"/> Cortisone medication	<input type="checkbox"/> Drug addiction
<input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fainting or dizzy spells	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Herpes	<input type="checkbox"/> HIV antibody or AIDS	<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Kidney disease/dialysis
<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Tumor	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Stomach problems	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Ulcers			
<input type="checkbox"/> NONE			

- For women.**
- 1) Are you pregnant?..... YES NO
 - 2) Are you looking to become pregnant?..... YES NO
 - 3) Are you nursing?..... YES NO

Please read and initial.
 I understand it is my responsibility to inform the office if I am pregnant, looking to become pregnant, or nursing since it will affect my dental care and the scheduling of appointments. _____

- 4) Are you using a contraceptive?..... YES NO
- If yes, please read and initial.*
 I understand that taking antibiotics may render contraceptives ineffective. _____

Do you have any disease, condition, or problem that was not previously listed?..... YES NO
 If yes, please describe here: _____

DENTAL NEEDS SURVEY

Date of your last dental appointment? _____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What type of oral hygiene tools do you use? _____

Do your gums bleed at any time?..... YES NO

Do you have aching or sensitive teeth?..... YES NO

Have you ever had an injury to your face or jaw?..... YES NO

Do you presently have or have you had *pain or discomfort* in the mouth, face, jaws or jaw joints (TMJs)?... YES NO

Have you had trouble associated with any previous dental treatment?..... YES NO

Please rate on a scale of 1-5 the importance of each of the following regarding your dental care (the most important would be #1):

_____ Preventive Dental Health Care

_____ Freedom From Pain

_____ Excellence & Quality of Service

_____ Cost & Affordability

_____ Other: _____

Please rate, as above, what a dentist has to do to gain your confidence:

_____ Show me what he/she is doing or needs to do so I can clearly understand what is happening.

_____ Listen to my concerns and explain thoroughly the procedures to be performed.

_____ Make sure I feel comfortable and informed at all times.

Please check the level of fear you have about your dental visits (10 being the greatest fear):

1 2 3 4 5 6 7 8 9 10

Are you concerned about the following (yes or no)?

_____ Existing discomfort?

_____ Whitening your teeth?

_____ Replacing old mercury silver fillings?

_____ Appearance of my smile?

_____ Recurring or untreated gum disease?

_____ Prevention of decay?

_____ Mouth odor?

_____ Other: _____

PLEASE CHECK ONE:

When discussing my treatment plan, I prefer:

THE BIG PICTURE

DETAIL BY DETAIL

When evaluating my smile, it's most important:

WHAT I SEE

WHAT OTHERS SEE

Do you have dental insurance? _____ YES _____ NO

If you did not have dental insurance, would you still have your dental care completed?

_____ YES _____ NO

Patient's Name: _____

To the best of my knowledge, all of the preceding "Patient Information" and health history answers are true and correct. I also understand that it is my responsibility to inform the office of any changes to my medical history prior to **all** appointments.

Signature of Patient/Guardian

Date

Reviewed by: _____
Signature of Doctor

Date

GENERAL FINANCIAL POLICY

If you have dental insurance, we want you to receive the full benefit of it. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We accept assignment of your insurance payment, another service to you. You are responsible for any applicable deductible amounts and the portion that your insurance does not cover. Please be advised that although our office will make every effort to accurately estimate what your insurance will pay, this **does not, in any way,** guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedure(s) rendered.

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

I hereby attest that I have read the above section and understand it completely.

Signature of Patient/Guardian

Date

Patient's Name: _____