A Brighter Smile Family and Cosmetic Dentistry, LLC

Date_____

Last Name	First Name	Address	City	State	Zip Code

Home Telephone	Cell Phone	Business Phone	Birth Date	Referred By

Medical History

Name of Physician_____

Address of Physician_____

My last physical examination was on:_____

Are you currently under medical treatment? Yes ___ No ____

If so, what are you being treated for? _____

_____

_____

When was your blood pressure last checked? _____ What was it? _____

Do you have or have you had any of the following diseases or medical conditions (circle yes or no):

Mitral valve prolapse or heart murmur	Yes	No	Diabetes/low blood sugar	Yes	No
Congenital heart problems	Yes	No	Hepatitis or liver disease	Yes	No
Damaged heart valves	Yes	No	Kidney disease	Yes	No
High blood pressure	Yes	No	Arthritis or rheumatism	Yes	No
Pacemaker	Yes	No	AIDS or lupus	Yes	No
Asthma or breathing problems	Yes	No	Ulcers or digestive problems	Yes	No
Allergies and/or hives	Yes	No	Psychiatric/emotional	Yes	No
Sinus trouble or hay fever	Yes	No	Blood disorders	Yes	No
Epilepsy or seizures/fainting	Yes	No	Any joint replacements	Yes	No

Please circle and <u>list</u> any medications you are taking:

			Name of Medication
High blood pressure medication	Yes	No	_____
Heart medication	Yes	No	_____
Blood thinners	Yes	No	_____
Aspirin	Yes	No	_____
Antibiotics	Yes	No	_____
Steroids	Yes	No	_____
Antihistamines or allergy medication	Yes	No	_____
Mood stabilizers or anti-anxiety drugs	Yes	No	_____
Oral Contraceptives	Yes	No	_____
Nutritional supplements	Yes	No	_____
Any drugs/medications not listed			_____

Are you <u>allergic</u> or have you <u>reacted adversely</u> to any of the following (circle yes or no):

Penicillin	Yes	No	Latex or rubber	Yes	No
Other antibiotics	Yes	No	Costume or inexpensive jewelry	Yes	No
Codeine or Vicodin	Yes	No	Other _____		
Aspirin	Yes	No			

Women Only (circle yes or no and explain if needed)

Are you pregnant? (Yes or No)_____ Due date:_____

Do you have any problems associated with your menstrual period? Yes No _____

_____

Are you nursing? Yes No _____

Are you planning on nursing? Yes No _____

Dental History

What is the reason for your visit today? _____

When was your last dental exam?_____Last cleaning?_____Last x-rays?_____

Previous dentist?_____

What was done at your last dental visit?_____

_____

Do you have any dental problems or concerns right now?_____

What did you like least about your last dental office?_____

Are any of your teeth sensitive to (circle yes or no):

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or chewing?	Yes	No
Brushing?	Yes	No

Have you noticed the following (circle yes or no):

Bleeding gums?	Yes	No
Mouth odors?	Yes	No
Loose teeth?	Yes	No
Food trap areas?	Yes	No

Do you (circle yes or no):

Clench or grind your teeth?	Yes	No
Breathe through your mouth?	Yes	No
Wake up with tired jaws?	Yes	No
Smoke or chew tobacco?	Yes	No
Have jaw joint popping?	Yes	No

Would you like whiter teeth or a more attractive smile? (circle yes or no)

Yes No

Do you smoke or use tobacco products of any kind or have you ever done any of the above? (circle yes or no)

Yes No

Have you ever had (circle yes or no):

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Gum treatment?	Yes	No
Gum surgery?	Yes	No
Bruxism/night guard	Yes	No
TMJ appliance/bite guard	Yes	No

Do you get frustrated because you always have new cavities or something has to be repaired on a frequent basis? (circle yes or no)

Yes No

Do you feel you will eventually have dentures? (circle yes or no)

Yes No

Do you want to control dental disease and keep your own teeth? (circle yes or no)

Yes No

Please circle any of the following that apply:

I would like my teeth to be whiter.	Yes	No
I do not like my silver/black fillings	Yes	No
I sometimes hide my teeth when I smile.	Yes	No
I have discolored fillings that I don't like.	Yes	No
The color of my teeth is too dark.	Yes	No
I think my teeth are shaped funny.	Yes	No
I have spaces between my teeth I don't like.	Yes	No

Is there anything else about your past dental treatment that you would like us to know?

_____

_____

Signature of Patient/Responsible Party on Account_____

Date_____