MEDICAL HISTORY

Patient Name:	Date of Birth:
Social Security Number:	Employer:
Address:	Home Phone: Cell Phone: Work Phone:
E-Mail Address:	Preferred Pharmacy: Location:

Please list any prescriptions you are currently taking & their purpose:_Drug:______________Purpose:________________

Drug:______________________Purpose:__________________ Drug:_____________________Purpose:________________

Drug:______________________Purpose:__________________ Drug:_____________________Purpose:________________

Drug:______________________Purpose:__________________ Drug:_____________________Purpose:________________

Please list any herbal medications/supplements/vitamins you are currently taking:_________________________________

____

Please list any medical allergies/bad reactions you may have (i.e. penicillin, sulfa, latex, milk, nuts, red dye, etc.):

____

Physician's Name and Location:____

When was your last complete physical including blood tests?____

When was your most recent visit to physician and the reason:____

What is your estimate of your general health? Excellent Good Fair Poor

Do we have permission to consult with your physician? Yes No
Are you currently receiving **intravenous** Biphosphonates? Yes No
If Yes, for how long:_________________________
Are you currently taking **oral** Biphosphonates (e.g. Fosamax, Actonel, Boniva)? Yes No
If Yes, for how long:_________________________

Women only: Are you currently pregnant? Yes No
If Yes, expected due date:_________________
Are you currently nursing? Yes No

Indicate which of the following you have had, or have at present. Circle "yes' or "no" to each item.

Condition		
Hospitalization	Yes	No
Heart disease/heart problems	Yes	No
Cardiac stent within last 6 months	Yes	No
History of infective endocarditis	Yes	No
Artificial heart valve/ or repaired heart defect	Yes	No
Pacemaker/implantable defibrillator	Yes	No
Orthopedic implant (e.g. joint replacement)	Yes	No
Organ transplant	Yes	No
High or low blood pressure	Yes	No
Stroke (taking blood thinners)	Yes	No
Anemia or other blood disorder	Yes	No
Prolonged bleeding (or INR > 3.5)	Yes	No
Pneumonia, emphysema, sarcoidosis	Yes	No
Breathing problems/short breath	Yes	No
Chronic ear infections	Yes	No
Hearing disorder	Yes	No
Tuberculosis, measles, chicken pox	Yes	No
Sleep problems (e.g. apnea, snoring, insomnia, restless sleep, bedwetting)	Yes	No
Kidney disease/trouble	Yes	No
Liver disease or jaundice	Yes	No
Vertigo (e.g. room spinning)	Yes	No
Dizziness/Fainting	Yes	No
Thyroid, parathyroid disease, or calcium deficiency	Yes	No
Hormone deficiency or imbalance	Yes	No
High cholesterol, taking statin drugs	Yes	No
Diabetes (HbA1c=________)	Yes	No
Steroid therapy	Yes	No
Stomach or duodenal ulcer	Yes	No
Digestive or eating disorders (celiac, acid reflux, bulimia, anorexia)	Yes	No
Osteoporosis/osteopenia	Yes	No
Arthritis or gout	Yes	No
Autoimmune disease	Yes	No
Head or neck injuries	Yes	No
Headaches/Migraines	Yes	No
Epilepsy, convulsions (seizures)	Yes	No
Neurological disorders (e.g. Alzheimers, dementia)	Yes	No
Viral infections/cold sores	Yes	No
Lumps or swelling in the mouth	Yes	No
Hives, skin rash, hay fever	Yes	No
STI/STD/HPV	Yes	No
Hepatitis (Type__________)	Yes	No
HIV/AIDS	Yes	No
Tumor, abnormal growth	Yes	No
Radiation therapy	Yes	No
Chemotherapy, immune suppressive medications	Yes	No
Emotional difficulties	Yes	No
Nervous/Anxious	Yes	No
Psychiatric treatment/antidepressants	Yes	No
Concentration problems (ADD/ADHD)	Yes	No
Frequent exhaustion or fatigue	Yes	No
Alcohol/recreational drug use	Yes	No
Tobacco use	Yes	No

If anything circled "yes' above needs further explanation, please describe:__________________________________

____

____

Do you have or have you had any disease, condition, or problem not listed?_______________________________

____

____

Patient/Guardian Signature:____Date:_____________

Dentist Signature:____Date:______________

DENTAL HISTORY

Patient Name:____

Please answer "yes" or "no" to the following:

Personal History:

1. Are you fearful of dental treatment? How fearful, on a scale of 1(least) to 10(most) ________________ Yes No
2. Have you had an unfavorable dental experience?____ Yes No
3. Have you ever had complications from past dental treatment?__________________________________ Yes No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?__________________ Yes No
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, & at what age?___________Yes No
6. Have you had teeth removed, missing teeth that never developed or lost teeth due to injury?_________ Yes No

Gum and Bone:

7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?_________________ Yes No
8. Have you ever had gum disease, gum or bone loss between your teeth, or scaling/root planing?_______ Yes No
9. Have you ever noticed an unpleasant taste or odor in your mouth?_______________________________Yes No
10. Is there anyone with a history of periodontal disease in your family?______________________________Yes No
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?___________ Yes No
12. Have you ever had teeth become loose on their own, or do you have difficulty eating an apple?_______ Yes No
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?________ Yes No

Tooth Structure:

14. Have you had any cavities within the past 3 years?____ Yes No
15. Does the amount of saliva in your mouth seem too little or do you have trouble swallowing?__________Yes No
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?______________Yes No
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing some areas?____________ Yes No
18. Do you have grooves or notches on your teeth near the gum line?________________________________ Yes No
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?__________________ Yes No
20. Do you frequently get food caught between any teeth?_______________________________________ Yes No

Bite and Jaw Joint:

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)?_________ Yes No
22. Do you feel your lower jaw is being pushed back when trying to bite your back teeth together?________ Yes No
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars, or other food?________Yes No
24. In the past 5 years, have your teeth changed (become shorter, thinner or worn)?___________________ Yes No
25. Are your teeth becoming more crooked, crowded, or overlapped?________________________________ Yes No
26. Are your teeth developing spaces or becoming more loose?____________________________________ Yes No
27. Do you have trouble finding your bite (squeeze/tap teeth or shift your jaw to fit teeth together)?______ Yes No
28. Do you place your tongue between your teeth or close your teeth against your tongue?______________Yes No
29. Do you chew ice,bite your nails,use your teeth to hold objects, or have any other oral habits?__________ Yes No
30. Do you clench or grind your teeth together in the daytime or make them sore?_____________________Yes No
31. Do you have any problems with sleep, wake up with a headache or an awareness of your teeth?_______Yes No
32. Do you wear or have you ever worn a bite appliance?____ Yes No

Smile Characteristics:

33. Is there anything about the appearance of your mouth that you would like to change?_______________ Yes No
34. Have you ever bleached (whitened) your teeth?____ Yes No
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?_________________ Yes No
36. Have you been disappointed with the appearance of previous dental work?________________________Yes No

Patient Signature:___________________________________ **Doctor's Signature:**_________________________________

Consent for Services and Financial Policy

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to use the anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand I am financially responsible for all charges whether or not paid by insurance.
5. Lastly, I agree to be responsible for payment of all services rendered on my behalf or dependents. I understand that payment is due at time of service unless other arrangements have been made.
6. **I understand that Welcome Smiles reserves the right to charge a $40 fee for appointments cancelled with less than 48 hours notice, and I agree to pay this fee if applicable.**

Patient/Guardian Signature:____Date:______________________

Consent to Contact

By providing your cell phone number and/or email address, you consent to receive calls, texts, emails or electronic communications at the number or email address provided. This consent is for Provider and any affiliates, including any and all third-party entities hired by Provider for billing, collections, or customer care services. With your permission, we can provide you with electronic versions of documents associated with your account(s) at provider rather than in paper form.

HIPAA Acknowledgement

I have the right to request a copy of this office's Notice of Privacy Practices at any point.

I give permission to Welcome Smiles to discuss my dental treatment with the following people/Parents/Guardian:

____

____

Patient/Guardian Signature: ____ Date:_________________________