

welcome smiles

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

Hospitalization_____	Yes	No	Steroid therapy_____	Yes	No
Heart disease/heart problems_____	Yes	No	Stomach or duodenal ulcer_____	Yes	No
Cardiac stent within last 6 months_____	Yes	No	Digestive or eating disorders (celiac, acid reflux, bulimia, anorexia)_____	Yes	No
History of infective endocarditis_____	Yes	No	Osteoporosis/osteopenia_____	Yes	No
Artificial heart valve/ or repaired heart defect_____	Yes	No	Arthritis or gout_____	Yes	No
Pacemaker/implantable defibrillator_____	Yes	No	Autoimmune disease_____	Yes	No
Orthopedic implant (e.g. joint replacement)_____	Yes	No	Head or neck injuries_____	Yes	No
Organ transplant_____	Yes	No	Headaches/Migraines_____	Yes	No
High or low blood pressure_____	Yes	No	Epilepsy, convulsions (seizures)_____	Yes	No
Stroke (taking blood thinners)_____	Yes	No	Neurological disorders (e.g. Alzheimers, dementia)_____	Yes	No
Anemia or other blood disorder_____	Yes	No	Viral infections/cold sores_____	Yes	No
Prolonged bleeding (or INR > 3.5)_____	Yes	No	Lumps or swelling in the mouth_____	Yes	No
Pneumonia, emphysema, sarcoidosis_____	Yes	No	Hives, skin rash, hay fever_____	Yes	No
Breathing problems/short breath_____	Yes	No	STI/STD/HPV_____	Yes	No
Chronic ear infections_____	Yes	No	Hepatitis (Type_____)	Yes	No
Hearing disorder_____	Yes	No	HIV/AIDS_____	Yes	No
Tuberculosis, measles, chicken pox_____	Yes	No	Tumor, abnormal growth_____	Yes	No
Sleep problems (e.g. apnea, snoring, insomnia, restless sleep, bedwetting)_____	Yes	No	Radiation therapy_____	Yes	No
Kidney disease/trouble_____	Yes	No	Chemotherapy, immune suppressive medications_____	Yes	No
Liver disease or jaundice_____	Yes	No	Emotional difficulties_____	Yes	No
Vertigo (e.g. room spinning)_____	Yes	No	Nervous/Anxious_____	Yes	No
Dizziness/Fainting_____	Yes	No	Psychiatric treatment/antidepressants_____	Yes	No
Thyroid, parathyroid disease, or calcium deficiency_____	Yes	No	Concentration problems (ADD/ADHD)_____	Yes	No
Hormone deficiency or imbalance_____	Yes	No	Frequent exhaustion or fatigue_____	Yes	No
High cholesterol, taking statin drugs_____	Yes	No	Alcohol/recreational drug use_____	Yes	No
Diabetes (HbA1c=_____)	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

I hereby authorize this dental practice, Welcome Smiles and dental providers Dr. Vivek Mehta, Dr. Bradford Craigen, and Dr. Rebecca Tsai to take radiographs, study models, photographs, or any other diagnostic aids they deem appropriate to make a thorough diagnosis of my dental needs. I also authorize this dental practice and dental provider, as referenced below, to perform any and all forms of treatment, medication, and therapy that may be indicated, including, but not limited to, examinations, local anesthetic, restorative treatment, and preventive treatment.

In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

Radiographs (X-Rays) - Dental x-rays help detect problems early. If untreated, these problems may become painful or cause tooth loss. Your insurance may not cover x-rays. Pregnancy: We do not take x-rays on pregnant patients unless urgently needed. Please inform us if you are or may be pregnant.

Drugs and Medications - I understand that I may receive a local anesthetic and/or other medications. In rare instances, patients may have a severe reaction to the anesthetic, which may require emergency medical attention, or find that it reduces their ability to control swallowing. This increases the chance of swallowing or aspirating foreign objects during treatment. As part of dental treatment, items including, but not limited to, crowns and bridges, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

Nerve injury may occur from the procedure and/or the delivery of local anesthesia, resulting in altered or loss of sensation, numbness, pain, altered feeling in the face, cheek(s), lips, chin, teeth, gums, and/or tongue (including loss of taste), or loss of some senses, including the sense of smell or vision. Such conditions may resolve over time, but in some cases may be permanent.

Possible Risks of Dental Treatment:

- Tooth sensitivity to hot/cold or biting
- Tooth/teeth or root injury
- Gum recession after treatment
- Jaw stiffness or soreness
- Cracks, fractures, or damage to teeth/jaw joints
- Bite changes requiring adjustment
- Tooth brittleness or fractures
- Crowning/capping or extraction of treated teeth
- Swelling, bleeding, delayed healing, or scarring
- Allergic reactions to materials or medications
- Discomfort or changes in tooth spacing, bite, or speech
- Changes in tooth/smile appearance
- Recurrent decay, fracture, infection, or gum disease

Smoking, nail-biting, alcohol, poor oral hygiene, and tongue piercings may reduce treatment success.

Patient Responsibilities:

- Follow home-care instructions
- Take prescribed medications as directed
- Keep all appointments and return for recommended visits
- Report any complications promptly

Records and Financial Responsibility - I authorize the release of any information, including the diagnosis, radiographs, and records of any treatments or examinations to my insurance company, consulting professionals, or others that may request my records.

I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorneys and collection fees. Payment is due when services are rendered unless other arrangements are made before treatment begins.

This general informed consent may remain in effect until treatment is terminated either by the patient, or this dental practice and dental provider, and/or the patient is no longer regarded as a patient of record.

Compliance - I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise. My failure to comply could result in complications or less than optimal results.

Acknowledgement - I acknowledge that no guarantee, warranty, or assurance has been given that the proposed treatment will be successful. In most cases, treatment should provide benefits in reducing the cause of my condition and promote healing, which will help me keep my teeth. Due to individual patient differences, however, a dentist cannot predict certainty of success.

I confirm that I understand this form and the information contained herein. I am a native speaker of English or have been offered the services of a qualified translator who has explained the information in my native tongue.

Signature of Patient: _____ Date: _____

Signature of Dentist: _____ Date: _____

If minor, Legal Guardian Name: _____ Signature: _____ Date: _____

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 or Guardian Signature: _____ **Date:** _____