GLOWING SMILE
DENTAL CARE

Name_____ Sex: M / F Today's Date: _____
Last First MI
If patient is a minor, please provide parent's/guardian's name: _____

MEDICAL HISTORY

Do you have a personal physician? Y N
Are you currently under a physican's care? Y N
Physican's Name: _____
Phone#: _____ Date of last visit _____
Reason for last physican visit: _____
Your current physical health is:
Good Fair Poor
Do you smoke or use tobacco in any form? Y N
Do you have any implants, valves, rods or pins? Y N
Are you taking any medications? Y N
Please list: _____
_____
_____
Have you ever taken Phen-Fen/Redux/Pondimin? Y N
If yes, when? _____

FOR WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N Week#: _____
Are you nursing? Y N

Have you ever had any of the following diseases or medical problems

Y N	Alcohol/drug abuse	Y N	Hepatitis
Y N	Anemia	Y N	Herpes/Fever blisters
Y N	Arthritis	Y N	High Blood Pressure
Y N	Artificial joints/valves	Y N	HIV+/AIDS
Y N	Asthma	Y N	Hospitalized for any reason
Y N	Bleeding Problem	Y N	Kidney Problems
Y N	Blood transfusion	Y N	Liver disease
Y N	Cancer/Chemotherapy	Y N	Low Blood Pressure
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Pacemaker
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Emphysema	Y N	Radiation Treatment
Y N	Epilepsy	Y N	Rheumatic Fever
Y N	Fainting/dizzy spells	Y N	Seizures
Y N	Frequent headache/migraine		
Y N	Heart attack	Y N	Sickle cell trait/disease
Y N	Heart murmur	Y N	Sinus problems
Y N	Heart surgery	Y N	Stroke
Y N	Hemophilia	Y N	Ulcers

Please list any other serious medical condition(s) that you have had which are not listed above:
_____
_____

Are you allergic to any of the following? (Please circle all that apply)

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that you are allergic to:
_____
_____

DENTAL HISTORY

What is the primary reason for your visit to our practice today?
_____
_____

Are you currently in pain? Y N
Do you require antibiotics before dental treatment? Y N
YOUR CURRENT DENTAL HEALTH IS:
Good Fair Poor
When was the last time you had a complete dental evaluation?
_____
Have you ever had a serious/difficult problem associated with any previous dental work? Y N
Do you floss regularly? Y N
Brush daily? Y N
Have you ever been informed or treated for the following dental conditions:

Y N	Bleeding gums	Y N	Mobility of teeth
Y N	Bad taste/odor	Y N	Oral cancer/biopsy
Y N	Cold sores/ulcers	Y N	Oseeous surgery
Y N	Deep cleanings/scalings	Y N	TMJ/TMD Joint pain
Y N	Gum/Periodontal Disease		
Y N	Toothbrush abrasion	Y N	Hot/Cold Sensitivity
Y N	Wisdom teeth extraction		

Would you like fresher breath? Y N
Would you be interested in whiter teeth? Y N
Are you happy with the way your smile looks? Y N
If not what would you change? _____
_____

I understand that the information I have given today is correct and accurate 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 this office of any changes in my medical status. I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

Patient's (parent) Signature Date

Doctor's Comments/Notes: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

I verbally reviewed the medical/dental information with the patient (parent) named herein.

Reviewer's Signature Date

First Update
Any changes: _____
Patient's (parent) Signature: _____ Date: _____ Reviewed By: _____

Second Update
Any changes: _____
Patient's (parent) Signature: _____ Date: _____ Reviewed By: _____

Third Update
Any changes: _____
Patient's (parent) Signature: _____