

LifeSmiles of New Hope, P.C.

PATIENT HISTORY

Name of Patient: _____ Age _____ Date of Birth _____ Today's Date _____

MEDICAL HISTORY – Please answer each question. Circle Yes or No Physician: _____ Tel# _____

- Yes No Are you presently in good health? If NOT, describe _____
- Yes No Have you been hospitalized or had a serious illness in the last 3 years? Describe _____
- Yes No Do you bruise easily or have abnormal blood clotting? Describe _____
- Yes No Have you ever taken Fen-Fen, Redux, or Biphosphonate drugs for cancer or osteoporosis?
- Yes No Do you smoke or use tobacco products? If yes, describe _____
- Yes No (WOMEN ONLY) Are you pregnant? If yes, Due Date _____. If No, taking birth control pills? _____
- Yes No Do you take ANY medications? If yes, please List _____
- Yes No Are you allergic to or had a reaction to ANY medications? If yes, please List _____
- Are you allergic to LATEX? Yes No Are you allergic to Costume Jewelry? Yes No

Describe below or attach another page to tell us about and medical conditions not listed on this form.

Do you have or ever had any of the following? (please check appropriate condition)

- | | | |
|-----------------------------|-----------------------|---|
| ___ Rheumatic Fever | ___ Anemia | ___ Chemotherapy/Radiation |
| ___ Heart condition | ___ Diabetes | ___ GERD, IBS, Chron's |
| ___ Kidney condition | ___ Glaucoma | ___ VD, HIV, AIDS, HEPATITIS, JAUNDICE |
| ___ Liver condition | ___ Nervous condition | ___ Fainting spells / Seizures |
| ___ High/Low Blood Pressure | ___ Eating disorders | ___ Mental Health care: Diagnosis _____ |

DENTAL HISTORY – Please answer each question. Circle Yes or No. Place a check mark when appropriate.

Name, Address, and Tel# of your previous dentist _____

Date of last dental visit _____ What was done? _____

- Yes No Are you nervous when visiting the dentist? Describe _____
- Yes No Do you feel your breath is offensive at times? Describe _____
- Yes No Do your gums ever bleed or hurt? Describe _____
- Yes No Have you noticed your teeth shifting or a change in your bite?
- Yes No Have you ever had gum treatment or surgery? Where? _____

What was done? _____ When _____

- Yes No ___Do you have Chronic Headaches? ___Pain in Jaw Joints? ___Clicking/Popping/Locking of jaw joints?
- Yes No ___Do you clench or grind your teeth? ___Earaches? ___Ringing of the ears or dizziness?
- Yes No Are any of your teeth sensitive to: ___Hot ? ___Cold? ___Sweets? ___Pressure?
- Yes No Have you had any Orthodontic work? Describe _____
- Yes No Are you happy with the Size, Color, Shape, Position of your teeth?
- Yes No Do you have old fillings or dental work that you DO NOT like the appearance of?

List some of your dental concerns: _____

If you had a magic wand, what would you change about your smile: _____

It is the patient's responsibility to inform our office of any changes in their medical condition. Initials _____

I certify that the above information is complete and accurate. Initials _____

Patient or Gaurdians Signature: _____ Date: _____

Dentist Signature: _____ Date: _____