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 hosptalized 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: ___________________