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Natural Smiles by design PC

SECTION A **Medical and Dental History**

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent

Patient Name:_____ _____ _____ Title:_____ Gender:_____
Last First MI Mr/Ms/Mrs/etc M/F

Would you consider yourself to be in fairly good health?
❍ Yes ❍ No

Within the past year, have there been any changes in your general health?
❍ Yes ❍ No

What is the date (or approximate date) of your last medical exam?_____ _____
Date Reason for visit

Your Primary Care Physician_____ _____ _____
Name Address Phone

Please MARK any of the following to INDICATE YES in response to the question

Medical

❍ Are you currently under the care of a physician due to a specific condition?
❍ Have you been hospitalized within the last 5years due to surgery or illness?
❍ Do you use tobacco (smoking or chewing)?
❍ Are you pregnant?
❍ Do you require the use of glasses or contacts?

❍ Taking Pre-Med	❍ Blood Disease	❍ High Blood Pressure
❍ Allergy- Aspirin	❍ Cancer	❍ HIV
❍ Allergy-Latex	❍ Diabetes	❍ Jaundice
❍ Allergy-Codeine	❍ Dizziness	❍ Kidney Disease
❍ Allergy-Penicillin	❍ Epilepsy	❍ Liver Disease
❍ Allergy-Erythro	❍ Excessive Bleeding	❍Mental Disorder
❍ Allergy-Sulfa	❍ Fainting	❍ Nervous Disorder
❍ Allergy-Hay Fever	❍ Glaucoma	❍ Pacemaker
❍ Anemia	❍ Head Injuries	❍ Radiation Treatment
❍ Arthritis	❍ Heart Disease	❍ Respiratory Problems
❍ Artificial Joints	❍ Heart Murmur	❍ Rheumatic Fever
❍ Asthma	❍ Hepatitis	❍ Rheumatism
❍ Sinus Problems	❍ Stomach Problems	❍ Stroke
❍ Tuberculosis	❍ Tumors	❍ Ulcers
❍ Venereal Disease		

❍ Do you have any conditions or diseases, etc. we should be aware of?
List _____
❍ Are you currently taking any prescription or non-prescription medications?
List_____
_____
_____

Dental

❍ Have you ever had complications following dental treatment?
❍ Have you ever had an unpleasant dental experience?
❍ Are you happy with your smile?
❍ Do your gums bleed when you brush or floss?
❍ Do your teeth experience sensitivity to cold or hot temperatures?
❍ Are any of your teeth currently causing you pain
❍ Do you grind your teeth (either consciously or during sleep)?
❍ Are any of your teeth loose?
❍ Would you like to change the color of your teeth?
❍ Is this an emergency visit?
❍ Is this visit for a second opinion?
If you could change anything about your teeth or smile, what would it be?
_____
Reason for your dental visit today?_____
When was your last dental visit?_____
What was done on your last dental visit?_____
Your Previous Dentist Name:_____
Your Previous Dentist Phone:_____

Treatment Authorization

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I understand that if I am not happy with the color of my teeth, whitening must be completed before any restorative treatment is rendered.

Signature_____Date_____