Patient Name_____ Date of Birth_____

Contos Smile Center, LTD

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have a primary physician? Yes No
Are you under physicians care now? Yes No If yes, please explain: _____

Physician's Name: _____ Phone: (____)_____ Date of Last Exam:_____

Have you been hospitalized or had a major operation? .....Yes No If yes, explain: _____

Any serious head or neck injury? .....Yes No If yes, explain: _____

Have you ever taken Fosamax, Boniva, Actonel or

any other medications containing bisphosphonates? . ....Yes No If yes, explain:_____

Are you on a special diet? .....Yes No If yes, explain: _____

Do you smoke or use tobacco? .....Yes No If yes, explain: _____

Do you use any controlled substances? .....Yes No If yes, explain:_____

Please provide a list of medications, pills or drugs you are **currently** taking?

List Medications: _____
_____
_____

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

- ○ **Aspirin**
- ○ **Codeine**
- ○ **Acrylic**
- ○ **Latex**
- ○ **Penicillin**
- ○ **Local Anesthetics**
- ○ **Any Metals**
- ○ **Sulfa Drugs**

List Other Allergies: _____

Do you have or have you had any of the following? (check all that apply)

- ☐AIDS/HIV +
- ☐Alzheimer 's Disease
- ☐Anaphylaxis
- ☐Anemia
- ☐Angina
- ☐Arthritis/Gout
- ☐Artificial Heart Valve
- ☐Artificial Joint
- ☐Asthma
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Breathing Problems
- ☐Cancer
- ☐Chemotherapy
- ☐Chest Pains
- ☐Cold Sores/Fever Blisters
- ☐Congenital Heart Disorder
- ☐Convulsions
- ☐Cortisone Medicine
- ☐Diabetes
- ☐Drug Addiction
- ☐Easily Winded
- ☐Emphysema
- ☐Epilepsy or Seizures
- ☐Excessive Bleeding
- ☐Excessive Thirst
- ☐Fainting (Spells/Dizziness)
- ☐Frequent Cough
- ☐Frequent Diarrhea
- ☐Frequent Headaches
- ☐Genital Herpes
- ☐Glaucoma
- ☐Hay Fever
- ☐Heart Attack/Failure
- ☐Heart Murmur
- ☐Heart Pacemaker
- ☐Heart Trouble/Disease
- ☐Hemophilia
- ☐Hepatitis A
- ☐Hepatitis B or C
- ☐Herpes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Hives or Rash
- ☐Hypoglycemia
- ☐Irregular Heartbeat
- ☐Kidney Problems
- ☐Leukemia
- ☐Liver Disease
- ☐Low Blood Pressure
- ☐Lung Disease
- ☐Mitral Valve Prolapse
- ☐Osteoporosis
- ☐Pain in Jaw Joints
- ☐Parathyroid Disease
- ☐Psychiatric
- ☐Radiation Treatments
- ☐Recent Weight Loss
- ☐Renal Dialysis
- ☐Rheumatic Fever
- ☐Rheumatism
- ☐Scarlet Fever
- ☐Shingles
- ☐Sick Cell Disease
- ☐Sinus Trouble
- ☐Spina Bifida
- ☐Stomach/Intestinal Disease
- ☐Stroke
- ☐Swelling of the Limbs
- ☐Thyroid Disease
- ☐Tonsillitis
- ☐Tuberculosis
- ☐Tumors or Growths
- ☐Ulcers
- ☐Venereal Disease
- ☐Yellow Jaundice
- ☐COVID-19

Other:
_____
_____
_____

Women Only (check all that apply)

Are You....

- Pregnant/ Trying to get pregnant? (Y) (N)
  If yes, delivery date: _____
- Taking Oral Contraceptives? (Y) (N)
- Nursing ? (Y) (N)

Note: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

revised 5/2020

Patient Name_____ Date of Birth_____

Contos Smile Center, LTD

Dental Health

What is your primary reason for being here today? _____

When was your last dental visit? _____ What was done? _____

Describe in your own words, what is most important to you about your visit today: _____

_____

Anything we should be aware of? (describe) _____

☐Yes ☐No Have you been under regular care by a dentist?
☐Yes ☐No Do your gums bleed while brushing & flossing?
☐Yes ☐No Are your teeth sensitive to sweets?
☐Yes ☐No Are your teeth sensitive to temperature?
☐Yes ☐No Do you have any loose teeth?
☐Yes ☐No Do any of your teeth ache?
☐Yes ☐No Do your gums bleed or have pain?
☐Yes ☐No Do your gums feel tender or swollen?
☐Yes ☐No Do you clench or grind your teeth?
☐Yes ☐No Do you notice popping in your jaw?
☐Yes ☐No Do you have frequent headaches?
☐Yes ☐No Do you wear a denture or partial?
☐Yes ☐No Are you tense during dental visits?
☐Yes ☐No Are you happy with the appearance of your teeth?

Smile Analysis

☐I wish my teeth were whiter
☐I grind my teeth to where the biting edges are chipped
☐I wish my teeth were straighter
☐I think my smile shows too much space between my teeth
☐I have gray, black, silver fillings that show when I smile
☐I am sometimes hesitant to smile
☐My old crowns have dark edges and don't look natural
☐Some of my teeth appear short and fat, too small or too large
☐I am concerned about the cost of enhancing my smile
☐I will like to hear about options to making my healthcare more affordable

How do you rate your smile on a scale of 1-10, with 10 being the best smile? _____

Comments _____

_____

_____

- I verify that the questions and information listed above have been answered to the best of my knowledge and that I have not omitted any pertinent information. I understand that providing incorrect information can be dangerous to me and my healthcare professionals. It is my responsibility to inform the dental office of any changes in my medical status.
- I authorize the dentist to release any information including the diagnosis of any treatment or examination rendered to me during the period of such dental care to the third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents. I understand that I will be informed of any treatment changes as they occur.
- I consent to allow my clinical photographs to be used by the doctors in an educational environment.

Signature of Patient, Parent or Guardian: _____ Date: _____

Print name: _____ Relationship to Patient: _____

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