SMILEY DENTAL GROUP

SMILEY · HOLOWICKI

5156 Blazer Parkway, Dublin, Ohio 43017

614-889-0726

www.smileydentalgroup.com

Medical/Dental History

Name (Last, First, Middle):_________________________Title: ______ Preferred Name: _____________

It is important that we know your medical and dental history. These facts have a direct bearing on the treatment provided in this office. Information is held in strict confidence.

Are you APPREHENSIVE about dental treatment?	_____ Yes	_____ No
Have you ever had Periodontal (GUM) treatment?	_____ Yes	_____ No
Have you ever had ORTHODONTIC (braces) treatment?	_____ Yes	_____ No
Do your gums BLEED, feel TENDER, or IRRITATED?	_____ Yes	_____ No
Are your teeth SENSITIVE to hot, cold, sweets or pressure?	_____ Yes	_____ No
Are you aware of GRINDING or CLENCHING your teeth?	_____ Yes	_____ No
Do you have HEADACHES, EARACHES OR NECK PAINS?	_____ Yes	_____ No

Are you unhappy with the appearance of your smile? Would you like it to look better or different?

If yes, please explain: ____

Why have you come to the dentist today? ____

Are you currently in pain? Please explain: ____

Previous Dentist: ______________________ Address: ____

Phone: ___________________________ Last dental visit: _______________________________________

Last X-Rays (If known, type Bitewings, Panorex or Full Series (18 single x-rays)): ____________________

Who referred you to our office? ____

Have you had any of the following problems or diseases? Please check.

Heart Disease/Attack	Kidney Disease/Trouble	Epilepsy/Seizures
Heart Surgery	Frequent Urination	Attention Deficit ADD
Heart Murmur	Liver Disease	Psychiatric Treatment
Rheumatic Fever	Hepatitis A/B/C	Cancer
Mitral Valve Prolapse	Blood Transfusion	Chemotherapy
Artificial Heart Valve	Hemophilia	Radiation
Heart Pacemaker	AIDS/HIV	STD/Veneral Disease
High Blood Pressure	Substance Abuse/Addiction	Diabetes
Stroke	Ulcers	Thyroid Disease
Anemia	Cold Sores/Fever Blisters	Emphysema
Artificial Joints	Tuberculosis	Arthritis
Family History of Oral Cancer	Family History of Perio. Disease	Asthma/Sinus Problems

Do you have any allergies? Yes No

If yes, please specify: ______________________________

____

Are you currently taking any medications? Yes No

If yes, please specify: ______________________________

____

Are you allergic or had any negative reactions to the following? Please check.

Local Anesthetics Penicillin Erythromycin Tetracycline Nitrous Oxide Codeine

Other: ______________________________

Do you currently or have you taken any prescription medications for the treatment of osteoporosis ie… Fosomax, Actonel, Aredia? Yes No

Have you ever had cancer treatment that involved bone replacement drugs like the above? Yes No

Do you have any other serious medical conditions? Please explain.

____

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Physician's Name: ______________ Are you currently under his/her care? Yes No

For women- Are you pregnant? Yes No

Responsible Party Signature: ______________________ **Date:** ____________

Revised 07/29/12