Please check ☑ those boxes which the answer is YES. If NO, Please check ☑ NO. If Unsure, Please circle. Mahalo!!

Patient's Medical History

Are you under a physician's care now?	○Y ○N	If yes, please explain:
Have you ever been hospitalized or had a major operation?	○Y ○N	If yes, please explain:
Have you ever had a serious head or neck injury?	○Y ○N	If yes, please explain:
Are you taking any medications, pills or drugs?	○Y ○N	If yes, please explain:
Do you take, or have you taken, Phen-Fenn or Redux?	○Y ○N	If yes, please explain:
Are you on a special diet?	○Y ○N	If yes, please explain:
Do you use tobacco?	○Y ○N	If yes, please explain:
Do you use controlled substances?	○Y ○N	If yes, please explain:

Women—Are you: Pregnant? ○Y ○N Taking oral contraceptives? ○Y ○N Nursing? ○Y ○N

Are you Allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other Allergies? ○Y ○N If yes, please explain:

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

Have you ever had any serious illnesses NOT listed above? ○Y ○N
Do you have any dental fears or concerns? ○Y ○N

Are you taking or have you ever taken Bisphosphonate? ○Y ○N

Smile Survey

Our Smile

All of us have one. Some of us use it more. But, some of us Use it less...and that's too bad because your smile is Something that can bring you Confidence!

Some of us are less confident with our smile because it may Have one or two obvious (but correctable) imperfections.

Are you concerned about any of these dental conditions?

☐ Yellow Teeth ☐ Chipped Teeth
☐ Stained Teeth ☐ Uneven Edges
☐ Missing Teeth ☐ Crooked Teeth
☐ Cracked Teeth ☐ Crowded teeth
☐ Red or Swollen Gums

These modern methods have won New Confidence for...

✧ Children ✧ Teens ✧ Adults ✧ Seniors
✧ Whitening ✧ Porcelain Veneers
✧ Bonding ✧ Crowns
✧ Bridges ✧ Tooth Colored Fillings

Please indicate the concerns you have about your smile.

We will set aside additional time to Review the dramatic affect today's Advanced Dentistry can have in creating *THE BEST SMILE EVER!*

History Review:

I understand that the information given here is, to the best of my knowledge, correct. I also understand this information will be held in STRICT CONFIDENCE; and

It is my responsibility to inform this office of any changes in my medical status. With my informed consent, I authorize the dental staff to perform any necessary dental service(s) indicated during diagnosis and treatment. I understand that I am financially responsible for any balance due. If I have insurance, I herby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for payment to be made. Finally, I understand that after 60 days a service charge of 18% annually will be charged monthly on any unpaid balance. I authorize the use of photographs of me taken for the purpose of patient education.

Signature of patient or if a minor (parent or guardian) Date