AESTHETIC DENTAL

ID: CHART ID: **COSMETIC & IMPLANT CENTER** www.dentalSCV.com

WE WOULD LIKE TO GET TO KNOW YOU BETTER

Full Name:_____ Today's Date:_____

Address:_____ City:_____ State/Zip:_____

Cell:_____ Work Phone:_____ Home Phone:_____

Birth Date:_____ Age:_____ Social Sec:_____

E-Mail:_____ Drivers Lic:_____

Sex ☐M ☐F ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Emergency Contact_____ Phone_____

Person Responsible For Your Dental Investments_____

Patient Employed By_____ Occupation_____

Date Of Last Dental Exam/X-Ray_____

Why Did You Leave Your Last Dentist?_____

How Did You Hear About Us?_____

WE WANT TO TAKE CARE OF YOUR CONCERNS AND NEEDS FIRST

What Are Your Present Dental Concerns?_____

Check ( ) If You Have Had Problems With Any Of The Following:

☐Bad Breath	☐Food Collection Between Teeth	☐Periodontal Treatment
☐Bleeding Gums	☐Grinding Teeth	☐Sensitive Teeth
☐Clicking or Popping Jaw	☐Loose Teeth or Broken Fillings	☐Sores or Growths In Your Mouth

Do You Avoid Brushing Any Part Of Your Mouth? ☐Yes ☐No

Does Dental Treatment Make You Nervous? ☐Yes ☐No

I Think My Dental Health Is ☐Excellent ☐Good ☐Fair ☐Poor

If I Could Change My Smile I Would Make My Teeth ☐Whiter ☐Straighter ☐Close Spaces ☐Repair Chips

How Often Do You Floss?_____ How Often Do You Brush?_____

Other Concerns/Needs Of Mine Are_____

Any Serious Trouble With Previous Dental Treatment?_____

PRIMARY INSURANCE INFORMATION

Name Of Insured:_____ Relationship To Patient: ☐Self ☐Spouse ☐Child ☐Other

Insured Soc. Sec:_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

City, State, Zip:_____ City, State, Zip:_____

MEDICAL HISTORY

Physician's Name:_____ Phone:_____ Date Of Last Visit:_____

Are You Currently Under Physician Care?_____ Please Describe:_____

Have You Had Any Serious Illnesses or Operations?_____ If Yes, Describe:_____

(Women) Are You Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No

Have you ever been hospitalized or had a major operation? ☐Yes ☐No If Yes_____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes_____

Are you taking any medications, pills, or drugs? ☐Yes ☐No If Yes_____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If Yes_____

Have you ever taken Fosamax, Boniva, Actonel or any ☐Yes ☐No If Yes_____

Other medications containing Bisphosphonates? ☐Yes ☐No If Yes_____

Are you on a special diet? ☐Yes ☐No If Yes_____

Do you use tobacco? ☐Yes ☐No If Yes_____

Are You Allergic To Any Of The Following? ☐Asprin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa Drugs ☐Local Anesthetics

Other? ☐ Do You Use Controlled Substances?_____

Do You Have, or Have You Had, Any of The Following?

AIDS/HIV Positive ☐Yes ☐No	Cortisone Medicine ☐Yes ☐No	Hemophilia ☐Yes ☐No	Radiation Treatments ☐Yes ☐No
Alzheimer's Disease ☐Yes ☐No	Diabetes ☐Yes ☐No	Hepatitis A ☐Yes ☐No	Recent Weight Loss ☐Yes ☐No
Anaphylaxis ☐Yes ☐No	Drug Addiction ☐Yes ☐No	Hepatitis B or C ☐Yes ☐No	Renal Dialysis ☐Yes ☐No
Anemia ☐Yes ☐No	Easily Winded ☐Yes ☐No	Herpes ☐Yes ☐No	Rheumatic Fever ☐Yes ☐No
Angina ☐Yes ☐No	Emphysema ☐Yes ☐No	High Blood Pressure ☐Yes ☐No	Rheumatism ☐Yes ☐No
Arthritis/Gout ☐Yes ☐No	Epilepsy or Seizures ☐Yes ☐No	High Cholesterol ☐Yes ☐No	Scarlet Fever ☐Yes ☐No
Artificial Heart Valve ☐Yes ☐No	Excessive Bleeding ☐Yes ☐No	Hives or Rash ☐Yes ☐No	Shingles ☐Yes ☐No
Artificial Joint ☐Yes ☐No	Excessive Thirst ☐Yes ☐No	Hypoglycemia ☐Yes ☐No	Sickle Cell Disease ☐Yes ☐No
Asthma ☐Yes ☐No	Fainting Spells/Dizzy ☐Yes ☐No	Irregular Heartbeat ☐Yes ☐No	Sinus Trouble ☐Yes ☐No
Blood Disease ☐Yes ☐No	Frequent Cough ☐Yes ☐No	Kidney Problems ☐Yes ☐No	Spina Bifida ☐Yes ☐No
Blood Transfusion ☐Yes ☐No	Frequent Diarrhea ☐Yes ☐No	Leukemia ☐Yes ☐No	Stomach/Intestinal Disease ☐Yes ☐No
Breathing Problems ☐Yes ☐No	Frequent Headaches ☐Yes ☐No	Liver Disease ☐Yes ☐No	Stroke ☐Yes ☐No
Bruise Easily ☐Yes ☐No	Genital Herpes ☐Yes ☐No	Low Blood Pressure ☐Yes ☐No	Swelling of Limbs ☐Yes ☐No
Cancer ☐Yes ☐No	Glaucoma ☐Yes ☐No	Lung Disease ☐Yes ☐No	Thyroid Disease ☐Yes ☐No
Chemotherapy ☐Yes ☐No	Hay Fever ☐Yes ☐No	Mitral Valve Prolapse ☐Yes ☐No	Tonsillitis ☐Yes ☐No
Chest Pains ☐Yes ☐No	Heart Attack/Failure ☐Yes ☐No	Osteoporosis ☐Yes ☐No	Tuberculosis ☐Yes ☐No
Cold Sores/Fever Blisters ☐Yes ☐No	Heart Murmur ☐Yes ☐No	Pain in Jaw Joints ☐Yes ☐No	Tumors or Growths ☐Yes ☐No
Congenital Heart Disorder ☐Yes ☐No	Heart Pacemaker ☐Yes ☐No	Parathyroid Disease ☐Yes ☐No	Ulcers ☐Yes ☐No
Convulsions ☐Yes ☐No	Heart Trouble/Disease ☐Yes ☐No	Psychiatric Care ☐Yes ☐No	Venereal Disease ☐Yes ☐No
			Yellow Jaundice ☐Yes ☐No

Have You Ever Had Any Serious Illness Not Listed ☐Yes ☐No If Yes_____

Are You Currently Taking Any Medication?_____

Do You Drink Alcoholic Beverages? ☐Yes ☐No Do You Smoke? ☐Yes ☐No

I CERTIFY TO THE BEST OF MY KNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND THAT IF THERE ARE ANY CHANGES IN THE ABOVE, I AGREE TO NOTIFY MY DENTIST BEFORE MY NEXT VISIT.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this health history form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation, and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs. I also acknowledge that any photographs taken can or will be used for teaching, marketing or demonstration purposes. I have received a copy of the Dental Material Fact Sheet as required by law. Authorization must be signed by the patient, or by nearest relative in the case of a minor when the patient is physically or mentally incompetent.

Comments:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature Of Patient, Parent or Guardian: X_____ DATE:_____

Signature Of Doctor: X_____ DATE:_____

Recall Updates - Office Use Only

Date:_____	Date:_____	Date:_____
Health Changes:_____	Health Changes:_____	Health Changes:_____
Medicine:_____	Medicine:_____	Medicine:_____
Patient's Signature_____	Patient's Signature_____	Patient's Signature_____