5445 Village Dr., Suite100
Viera, FL 32955
321-751-7775
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SMILE DESIGN CENTER

HEALTH INFORMATION:

Last_____First_____ Date_____

MEDICAL HISTORY

1. Are you experiencing any medical problem now? _____
2. Are you currently taking any medications, drugs, pills, or nutritional supplement? Please list _____
   _____
3. Are you currently or have you ever taken bisphosphonates (ex: Fosamax, Didronel, Aredia)? _____
4. Are you allergic or have you reacted adversely to: (check those that apply) ☐ Aspirin ☐ Codeine
   ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Antibiotics ☐ Novocaine
   ☐ Metals, if so which _____ ☐ Other _____
5. Please describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
6. Do you use any tobacco products? ☐ No ☐ Yes If yes, what and how much per day?_____
7. Name of your Physician:_____ Phone No._____
8. Have you been hospitalized in the past 5 years? If yes, please explain._____
   _____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

- ☐ **Heart Failure**
- ☐ **Heart disease or Attack**
- ☐ **Angina Pectoris**
- ☐ **High Blood Pressure**
- ☐ **Heart Murmur**
- ☐ **Rheumatic Fever**
- ☐ **Congenital Heart Lesions**
- ☐ **Mitral Valve Prolapse**
- ☐ **Artificial Heart Valve**
- ☐ **Heart pacemaker**
- ☐ **Heart surgery**
- ☐ **Joint (Hip, Knee) Replacement**
- ☐ **Anemia**
- ☐ **Stroke**
- ☐ **Kidney Trouble**
- ☐ **Ulcers**
- ☐ **Osteoporosis**
- ☐ **Emphysema**
- ☐ **Active Tuberculosis (TB)**
- ☐ **Asthma**
- ☐ **Hay Fever**
- ☐ **Sinus Trouble**
- ☐ **Allergies or Hives**
- ☐ **Diabetes**
- ☐ **Thyroid Disease**
- ☐ **Radiation Therapy**
- ☐ **Chemotherapy (Cancer, Leukemia)**
- ☐ **Arthritis**
- ☐ **Rheumatism**
- ☐ **Cortisone or Steroid Therapy**
- ☐ **Glaucoma**
- ☐ **Pain in Jaw Joints**
- ☐ **HIV Positive (AIDS)**
- ☐ **Hepatitis A (Infectious)**
- ☐ **Hepatitis B (serum)**
- ☐ **Hepatitis C**
- ☐ **Liver disease**
- ☐ **Blood Transfusion**
- ☐ **Drug Addiction**
- ☐ **Hemophilia**
- ☐ **Venereal Disease**
- ☐ **Cold Sore/Fever Blisters**
- ☐ **Epilepsy or Seizures**
- ☐ **Fainting or Dizzy Spells**
- ☐ **Nervousness**
- ☐ **Psychiatric Treatment**
- ☐ **Sickle Cell Disease**
- ☐ **Bruise or bleed easily**
- ☐ **Cosmetic Surgery**

Patient signature:

DENTAL HISTORY

1. What type of dental care are you most interested in?
   - ☐ Emergency Care (relief of pain)
   - ☐ Maintenance Care (patchwork treatment)
   - ☐ Incremental Care (developing and prioritizing a long range treatment program)
   - ☐ Complete Care (optimal treatment without delay)
   - ☐ Cosmetic & Esthetic Care
   - ☐ TMJ (Care of muscle & joint)
2. When did you last have dental treatment?_____
   What was done?_____
   Name of dentist:_____
   Due to HIPAA privacy regulations, you must request x-ray transfer yourself. Please ask for instructions.
3. Why are you seeking dental care now?_____
   _____
4. Are you having discomfort or complaints at this time?
   If so, please explain:_____
5. If you could change anything about your mouth, what would that be? _____
   _____
6. Have you had dental treatment recommended to you that you haven't completed? If so, why not? _____
   _____
7. What dental services have you had:
   ☐ Fillings ☐ Extractions ☐ Root Canals
   ☐ Caps or Crowns ☐ Fixed Bridges ☐ Removable Bridges
   ☐ Treatment of gum disease ☐ Dentures ☐ Implants
   ☐ Orthodontics ☐ Cosmetic Bonding or Laminates ☐ TMJ
   ☐ Bite Adjustment ☐ Other: _____
8. Please check the following that are applicable:
   ☐ Teeth are sensitive to hot, cold, or pressure
   ☐ Gums bleed at times ☐ Food wedges between teeth
   ☐ Bumps or swelling in the mouth
   ☐ Unpleasant taste/breath
   ☐ Unfavorable dental experience
9. Does dental care make you nervous?
   ☐ No ☐ Slightly ☐ Moderately ☐ Very
10. What can we do to help you be more comfortable?____
    _____