CONFIDENTSMILES OF LAURENS
CHANGING LIVES ONE SMILE AT A TIME

Patient Dental History

	Yes	No
Do your gums bleed while brushing or flossing?		
Are your teeth sensitive to hot or cold liquids or foods?		
Do you have you had any sores or lumps in or near your mouth?		
Have you ever had any head, neck, or jaw injuries?		
Do you have frequent headaches?		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently?		
Have you had any difficult extractions in the past?		
Have you had any prolonged bleeding following extractions?		
Have you had orthodontic treatment?		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
Do you like your smile?		
Have you experienced any of the following problems in your jaw?		
- Clicking		
- Pain		
- Difficulty opening or closing		
- Difficulty chewing		
Do you snore or have you been told you snore?		
Have you been diagnosed with Sleep Apnea?		
Do you wear a C-PAP or been told you needed one?		
If there was a non-surgical way to stop snoring, would you be interested?		

Name of previous dentist _____

Last Visit Date _____

Anything else you'd like us to know about your dental health? _____

_____

_____

Patient Medical History

	Yes	No
Are you under medical treatment now? **If yes, please explain below.**		
Have you even taken Fen-Phen/Redux?		
Have you ever taken any cancer medications containing bisphosphonates?		
Do you use tobacco?		
Do you use controlled substances?		
Do you wear contact lenses?		
Are you pregnant, nursing, or taking oral contraceptives? **If yes, please explain below.**		
Have you had a persistent cough not associated with illness, lasting more than 3 weeks?		
Have you ever been hospitalized within the last 5 years? **If yes, please explain below.**		
Are you taking any medication including non-prescription medicine? **If yes, please list below.**		
Do you wear dentures or partials? **If yes, date of placement:**		
Are you allergic to or have you had any reactions to the following? **Please circle.**		
- Local anesthetics – Penicillin/Antibiotics – Sulfa Drugs – Barbiturates		
- Sedatives – Iodine – Aspirin – Any metals – Latex rubber		
- Other:		
Do you have or have you had any of the following? **Please circle.**		
- High Blood Pressure – Heart Attack – Rheumatic Fever – Stroke		
- Fainting/Seizures – Diabetes – Kidney Disease – AIDS/HIV - Ulcers		
- Low Blood Pressure – Epilepsy/Convulsions – Leukemia – Chest Pains		
- Heart Disease – Cardiac Pacemaker – Heart Murmur – Angina		
- Emphysema – Cancer – Joint Replacement – Hepatitis/Jaundice		
- Sexually Transmitted Disease – Tuberculosis – Radiation Therapy		
- Recent Weight Loss – Hay Fever/Allergies – Respiratory Problems		
- Swollen Ankles – Asthma – Thyroid Problem – Anemia – Arthritis		
- Bleeding Disorders – Glaucoma – Liver Disease – Easily Winded		

Any explanations required from above: _____

_____

_____

_____