# Modern Smiles

Patient Name: ___________________________________________________________________

So we can better assist you with your dental concerns, please list in order of importance what is essential to you;

**Please mark 1-3, with 1 Being most important item.**

__Health preservation/keeping your teeth for life and eliminating any disease.
__Comfort and function/eating what you want to eat.
__Esthetics/how your smile looks.

If you have had dental treatment recommended in the past and did not proceed, what factors prevented you from scheduling?

___Cost
__Fear of Pain
__No time
__No insurance
__Didn't hurt/Didn't think I needed treatment
__Other (please explain) ________________________________________

## HEALTH HISTORY

| | | | |
|---|---|---|---|
| __AIDS | __DIABETES | __STROKE | __SWELLING OF FEET OR ANKLES |
| __ANEMIA | __EPILESPY/SEIZURES | __SCARLET FEVER | __TAKING FEN-PHEN OR REDUX |
| __ARTHRITIS | __FAINITNG/DIZZINESS | __MITRAL VALVE PROLAPSE | __THYROID PROBLEM |
| __ARTFICIAL HEART VALVE | __GLAUCOMA | __NERVOUS PROBLEMS | __TOBACCO HABIT ________HOW MUCH |
| __ASTHMA | __HEART ATTACK | __PAIN IN JAW | __TONSILITIS/LUNG DISEASE |
| __ARTIFICIAL JOINTS | __HEADACHES | __PACEMAKER | __TUBERCULOSIS |
| __BACK PROBLEMS | __HEART MURMER | __PROLONGED BLEEDING | __ULCER |
| __CANCER/TUMOR | __HEPATITIS A/B/C/D | __PSCYCHIACTRIC CARE | __VENERAL DISEASE |
| __CHEMICAL DEPENDENCY | __HIGH BLOOD PRESSURE | __RADIATION TREATMENT | __RESPIRATORY DISEASE |
| __CHEMOTHERAPY | __CIRCULATORY PROBLEMS | __HIV + __RHEUMATIC FEVER | __CONGENITAL HEART DISORDER |
| __CORTISONE TREATMENT | __IMMUNE DISORDER | __KIDNEY/LIVER DISEASE | ___MAJOR SURGERY, TYPE ____________________ |

__PREGNANT? DUE DATE __________________ BREAST FEEDING? __________

Do you need to take a pre-medication, if so which premedication? ____________________________________________

## MEDICATIONS

List all herbs and medications you are currently taking:

______________________________________________________________________________

______________________________________________________________________________

Have you taken Bisphosphate for bone density, such as: Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, Reclast or Zometa?______________________________________________________________________________

## ALLERGIES

☐Aspirin ☐ Barbiturates ☐ Codeine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other________________________

**The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of Modern Smiles responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature: ______________________________________________ Date: ______________________**