Medical History

Patient Name (Last, First,MI)_____ Date Of Birth _____Rate Health 1-10____
Height _____ Weight_____

PAST OR PRESENT CONDITIONS: First read all conditions in the list, *then* CIRCLE either "Yes" answers or "No" answers to the left

Any troubles, surgeries, defects, with these major organs:

Y N **Heart**: Attack, Angina/Pain, Murmur / MVP or other defect, Rapid Beat / Arrhythmias, Congestive Failure, Pacemaker / Defibrillator, Prior Infective Endocarditis, Surgeries: Valve Replacement, Bypass_____

Y N **Lung**: Asthma, Emphysema, Short of Breath, Cancer, TB, COPD, Other _____

Y N **Liver**: Hepatitis (types A,B,C), Jaundice / Cirrhosis, Enlargement, Cancer, Surgeries, Damage due to Alcohol or Drugs

Y N **Kidney / Bladder:** Stones, Cancer, Surgeries: Transplant, Removal, Non-Functioning_____

Please summarize any other surgeries or further details from above:_____

_____ _____

Do you have or have you had any of the following diseases, conditions or medical procedures?
No blanks, and please **circle appropriate selection** where more than one is listed.

Y N Blood Pressure, High or Low or Borderline
Y N Clotting / Bleeding Problems / Vascular Problems
Y N Anemia: Iron , Pernicious (B-12), Sickle Cell
Y N Stroke: Major, TIA's (mini)
Y N Diabetes: Circle 1 2 Are you a "brittle" diabetic? _____
Y N Other Endocrine (hormone) Problems?
Y N Poor or Delayed Healing
Y N Thyroid: Hyper (overactive) or Hypo (underactive)
Y N Seizures/Epilepsy
Y N Cancer/Tumors/ Leukemia
Y N Chemotherapy
Y N Radiation Therapy (for cancer)
Y N Occupational Radiation Exposure
Y N Skin Disorders / Rashes / Shingles
Y N HIV+/ AIDS/ ARC
Y N Any Other Infectious Conditions?
Y N Tobacco: Cigarettes, Cigars or Oral; pks/day ____ yrs_____
Y N Stomach, GI: IBD, GERD, Ulcers, U.Colitis, Crohn's, Gluten Allergy
Y N Fainting Spells
Y N Frequent Headaches / Migraines
Y N Head Injuries
Y N Learning: ADD / ADHD / Dyslexia
Y N Sleep Disorders / Apnea (CPAP used? _____)
Y N Venereal Disease
Y N Jaw Joint (TMJ) Disorders (Biteguard? _____)
Y N Jaw or Facial Surgery
Y N ENT: Circle: Eye, Ear, Nose, Throat, Sinus
Y N Do You Have Difficulty Swallowing?
Y N Nervousness / Depression
Y N Other Psychiatric Disorder (_____)
Y N Alcohol Abuse (treated? _____)
Y N Drug Abuse / IV Drug History
Y N Arthritis, Rheumatism; Back Pain, Neck Pain
Y N Artificial Bones / Joints Replaced? Date _____
Y N Glaucoma
Y N Multiple Sclerosis

Medicines & Drug Allergies

Y N Do You Have A **Latex Allergy**? (note: our office does not use latex)
Y N **Allergies To Any Medicines** (List. Include Antibiotics, Pain Killers, Local Anesthetics):_____
_____
Y N Have You Taken Any Prescription Steroids For More Than 2 Weeks in the Last 2 Years?_____
Y N BLOOD THINNERS other than aspirin? Coumadin/Warfarin; Plavix; Pradaxa, Xarelto, Eliquis; Cancer Medication: Avastin

Y N Osteoporosis Medicines? Circle: **alendronate (Fosamax), pamidronate (Aredia), risedronate (Actonel, Atelvia)**

zoledronate, (Zometa, Reclast, Aclasta), etidronate (Didronel), raloxifene (Evista), ibandronate (Boniva)

Y N Diet Pills (containing Phentermine or similar acting)

Women:
Y N Are You Pregnant? How Long? _____
Y N Are You Nursing?
Y N Are You Taking Birth Control Pills?

List All Medications, Including Dosage, Aspirin & Supplements; If none, write "None"; If attached, write "Attached":

_____
_____
_____
_____

Authorization For Treatment

I authorize the doctor and staff to perform any necessary dental services needed after diagnosis and oral discussion. I agree that the information filled out on this form is accurate and complete to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided, including medications.

Print Patient Name_____

Signature_____ Date _____
Patient, Parent, or Legal Guardian

DENTAL HISTORY

Patient Name _____ Date of Birth _____

What is Your Main Dental Concern (state if you are in pain)?_____
Approx. Date & Reason For Last Dental Visit _____
I usually brush _____ times per day and floss _____ times per _____

Y N Are You Satisfied With Your Previous Dental Care?
Y N Does food routinely trap between any of your teeth?
Y N Are You Aware of Any Clenching or Tooth Grinding?
Y N Pain in jaw muscles, around ears or jaw click or popping?
Y N Difficulty Opening or Closing Jaws?
Y N Do you wear a BiteGuard at night? Age of BG_____yrs
Y N Do Your Gums Bleed? (Circle) Brushing / Flossing
Y N Have you undergone any past periodontal (gum) therapies?
Y N N/A If missing any teeth, are you interested in Dental Implants?

Y N Are Your Teeth Sensitive to: _____Hot _____Cold?
Y N Are you dissatisfied with the appearance of your smile?
Y N Do you have old fillings or dental work which you perceive to be unattractive?
Y N Have you ever had a bad experience in a dental office?
Y N Past Orthodontic Treatment (braces)? Approximate Age _____
Y N I Am Interested in Orthodontics
Y N Do You Wear a Removable Partial Denture or Complete Denture? When Was It Made_____ Last Reline_____

Y N Do you feel nervous about dental treatment? If so, what can we do to alleviate your nervousness?
_____

Risk of Dental Caries (Decay, Cavities) Assessment
Y N Do you frequently drink any of the following for more than 15 minutes, separate from meals: (Circle all that apply)
Soft drinks (diet or regular), Sports Drinks, Tea or Coffee sweetened with Sugar, Fruit Juices?
Would you describe your style of eating as: (Circle) 1) Regular Meals with occasional snacks or 2) All day long Snacker or "Grazer"
Y N Do you feel you suffer from dry mouth? If so, what do you do about it, if anything? _____

If you had a magic wand and could change one thing about your smile, what would it be?
_____

How would you like your teeth to look in 15 years? _____

Authorization for Release of Information To Family and/or Friends

Kyle Taylor, DDS III, PLLC (d.b.a. Relax Dental) is authorized to release protected health information about the above named patient to entities listed here (list relationship):
_____

The above person(s) may receive the following information: (Please initial each that is subject to authorization)

_____Financial Information _____Information from exam findings, tests or x-rays _____Family Billing Information

Medical Information as follows:_____ Other Information as described:_____

May we leave information on your mobile or landline voicemail? _____

Rights of the Patient
I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to **Kyle Taylor, DDS III, PLLC.** I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ Date _____
Signature of Patient, Parent of Legal Guardian

Acknowledgement of Receipt of Notice of Privacy Practices

This form is posted in our office and is available online on our website at www.SmileSensationsDental.com
If requested, I have received a copy of the Notice of Privacy Practices.

_____ Date _____
Signature of Patient, Parent, or Legal Guardian