



LOUDOUN SMILE CENTER

NAME _____

HEALTH HISTORY & REGISTRATION

DATE _____

It is important that we know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

Last COMPLETE Dental Exam, Date:	Yes No	Do your gums BLEED, or feel TENDER or IRRITATED?	Yes No
Last FULL MOUTH XRAYS, Date: (16 Small Films or Panoramic)		Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)	<input type="checkbox"/> <input type="checkbox"/>
HOW LONG SINCE you have seen a dentist?		Does food get stuck in your teeth?	<input type="checkbox"/> <input type="checkbox"/>
How do you feel about your teeth?		Do you REGULARLY use DENTAL FLOSS?	<input type="checkbox"/> <input type="checkbox"/>
Are you having PROBLEMS now?	<input type="checkbox"/> <input type="checkbox"/>	Are you aware of GRINDING or CLENCHING your teeth?	<input type="checkbox"/> <input type="checkbox"/>
Please Describe _____		Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/> <input type="checkbox"/>
Do you wear DENTURES? (Partials or Full)	<input type="checkbox"/> <input type="checkbox"/>	Have you worn BRACES on your teeth (ORTHODONTICS)?	<input type="checkbox"/> <input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/> <input type="checkbox"/>	Have you had any PERIODONTAL (GUM) treatments?	<input type="checkbox"/> <input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENT?	<input type="checkbox"/> <input type="checkbox"/>	Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/> <input type="checkbox"/>
Are you UNHAPPY with the APPEARANCE of your teeth?	<input type="checkbox"/> <input type="checkbox"/>	Name of Previous Dentist?	
Would you like your smile to LOOK BETTER or DIFFERENT	<input type="checkbox"/> <input type="checkbox"/>	City:	State:
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/> <input type="checkbox"/>		

MEDICAL HISTORY

Do you have any CURRENT HEALTH PROBLEMS?	Yes No	Have you ever taken Fen-Phen <input type="checkbox"/> Redux <input type="checkbox"/> Coumadin <input type="checkbox"/>	Yes No
Are you under a PHYSICIAN'S CARE now? If yes, for what?	<input type="checkbox"/> <input type="checkbox"/>	Do you need to premedicate?	<input type="checkbox"/> <input type="checkbox"/>
		Are you PREGNANT/NURSING?	<input type="checkbox"/> <input type="checkbox"/>
		Do you use cigars/cigarettes, pipe or chewing tobacco? (circle)	<input type="checkbox"/> <input type="checkbox"/>

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

PLEASE ✓ YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Pos.	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
AIS	<input type="checkbox"/>	<input type="checkbox"/>	Cough (persistent)	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylaxis	<input type="checkbox"/>	<input type="checkbox"/>	Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes A1C _____	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatism)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Food allergies	<input type="checkbox"/>	<input type="checkbox"/>	Material allergies	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Surgical implant	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease or malfunction	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker/heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	_____			Rapid weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer/Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia (Abnormal bleeding)	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

Is there any other Medical or Dental information that you feel we should know about?

FAMILY PHYSICIAN _____
PHONE _____
LAST VISIT _____

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex (balloons, gloves, etc.)
Nitrous Oxide Codeine Penicillin

Are you aware of being allergic to any other medications or substances?
If yes, list: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

PATIENT Signature (Parent of Child) _____ Date: _____ DENTIST Signature _____