smilewave
IMPLANT & COSMETIC DENTISTRY

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# Medical & Dental Health History Form

**Please make sure to read, sign and date the back of this form.*

Patient Name (Last & First) ______ Name of Previous Dentist/Location ______ Date of Last Exam ______

## STEP 1 Dental Health History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Are you having any pain or discomfort at this time? |
| | | Are your teeth sensitive to: |
| ☐ | ☐ | Heat? |
| ☐ | ☐ | Cold? |
| ☐ | ☐ | Sweets? |
| ☐ | ☐ | Biting Pressure? |
| ☐ | ☐ | Does food catch between your teeth? |
| ☐ | ☐ | Do your gums bleed when brushing? |
| ☐ | ☐ | Have you noticed any gum swelling around your teeth? |
| ☐ | ☐ | Do you have an unpleasant taste or odor in your mouth? |
| ☐ | ☐ | Do you grind your teeth? |
| ☐ | ☐ | Problem of the Jaw: |
| ☐ | ☐ | Clinking of the jaw |
| ☐ | ☐ | Pain (joints, ear, side of face) |
| ☐ | ☐ | Difficulty opening or closing |
| ☐ | ☐ | Difficulty chewing |
| ☐ | ☐ | Do you ever avoid any part of the mouth while brushing? |
| ☐ | ☐ | Have you had a reaction to a local anesthetic? |
| ☐ | ☐ | Are you dissatisfied with your teeth & their appearance? |
| ☐ | ☐ | Are you deeply concerned about the finances required to return your teeth to excellent dental health? |
| ☐ | ☐ | Do you get frustrated because there is always something that needs to be treated when you visit a dentist? |
| ☐ | ☐ | Do you smoke? |
| ☐ | ☐ | Have you had any teeth removed other than wisdom teeth? |
| | | How long have these teeth missing? ______ |
| ☐ | ☐ | Do you feel you will eventually wear artificial dentures? |
| ☐ | ☐ | Do you have any fears? |

## STEP 2 Medical Health History

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you have any general health problems? |
| | | If so, please specify: ______ |
| ☐ | ☐ | Have you had surgery? |
| | | If so, please specify: ______ |
| ☐ | ☐ | Are you currently under a physician's care? |
| | | Reason: ______ |
| | | Any Medications? ______ |
| | | To the best of your knowledge, are you or have you ever been afflicted with: |
| ☐ | ☐ | Heart Problems: |
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Rheumatic Fever |
| ☐ | ☐ | Epilepsy |
| ☐ | ☐ | Respiratory Disease |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | HIV Positive |
| ☐ | ☐ | Prolonged Bleeding |
| ☐ | ☐ | Healing Complications |
| ☐ | ☐ | Allergy to any Drug? |
| ☐ | ☐ | Are you pregnant? |
| ☐ | ☐ | Have you been asked by your medical doctor to premedicate before any dental treatment? |
| ☐ | ☐ | Why did you leave your last dentist? ______ |
| ☐ | ☐ | What is your present dental problem? ______ |

Note:

## STEP 3 Acknowledgment with Consent to Proceed

1. I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any change at any subsequent appointment.

2. I authorize smilewave dentistry and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative, analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

3. I understand that the administration of local anesthetic may cause an unwanted reaction or side effects that may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

4. I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

5. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, that may or may not be achieved, for my benefit or the benefits of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask any questions.

## STEP 4 Please Sign & Date Below

| Signature of Patient/Legal Guardian | Relationship to Patient | Date |
|---|---|---|
| | | |

| Signature of Witness | Date |
|---|---|
| | |