Just Smiles
FAMILY AND COSMETIC DENTISTRY

ADULT MEDICAL & DENTAL HISTORY

Pt Name: ________________________________ Preferred name: _________ Birthdate: ____/___/____ Age:____

Physician's name: ______________________________ Phone #: __________________________

Are you allergic to any of the following? ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Latex ☐ Metals ☐ Sulfa Drugs
☐ Local Anesthetics ☐ Other _____________ ☐ I have no known allergies

Are you taking any medication by mouth at the present time? Please list name and reason, including over the counter drugs, vitamins or herbal remedies: ____

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Please indicate if you **have or ever had** any of the following medical conditions? (if yes, please explain)

☐ Abnormal, excessive bleeding
☐ ADD / ADHD
☐ Alcoholism / Drug addiction
☐ Allergies (hay fever)
☐ Anemia
☐ Any Surgery / Hospitalization
☐ Any type of transplant
☐ Arthritis
☐ Artificial heart valve
☐ Artificial hip / knee
☐ Asthma
☐ Cancer
☐ Chemotherapy
☐ Diabetes (type I or II)
☐ Epilepsy / Seizures
☐ Glaucoma
☐ Handicaps / Disabilities
☐ Hearing problems
☐ Heart Disease / Attack
☐ Heart Murmur
☐ Heart Pacemaker
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis Type:_____
☐ Herpes or cold sores
☐ High / Low Blood Pressure
☐ HIV positive, AIDS
☐ Jaundice
☐ Kidney / Liver Disease
☐ Mitral valve prolapse
☐ Radiation treatment
☐ Respiratory problems
☐ Rheumatic Fever
☐ Sinus Problems
☐ Smoker / Chewing tobacco
☐ Stroke
☐ Thyroid problems
☐ Tonsils / Adenoids removed
☐ Tuberculosis (TB)

Does your physician recommend antibiotics prior to dental visits? ☐ Y ☐ N ☐ I am not sure
For women only: Are you pregnant? ☐ Y ☐ N • Are you nursing? ☐ Y ☐ N • Are you taking birth control pills? ☐ Y ☐ N

Date of last dental visit: _______________ Reason for **last** dental visit: ________________________________

What is the reason for your visit **today**? ☐ Evaluation / Cleaning ☐ Toothache ☐ Cosmetic Evaluation
☐ Broken Tooth ☐ Snoring Device Evaluation ☐ Other _________________

Do your gums bleed? ☐ Yes ☐ No • Do you feel you have bad breath? ☐ Yes ☐ No
Have you ever needed a periodontal (deep) cleaning in the past? ☐ Yes ☐ No
Have you ever felt like you clench or grind your teeth? ☐ Yes ☐ No
Have you ever felt any lumps or bumps in your mouth? ☐ Yes ☐ No
Have you ever been interested in a whiter smile? ☐ Yes ☐ No
Have you ever thought about straightening out your teeth? ☐ Yes ☐ No
Are you interested in replacing your silver mercury fillings with white restorations? ☐ Yes ☐ No

Is there anything that might make you uncomfortable during your visit? (for example cold water or mint toothpaste)

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Is there anything we can do to make your visit more comfortable? ________________________________

I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical history. All information will be held in the strictest confidence. I authorize Just Smiles to perform the necessary dental services I will need.

_________________________________ _____________________
Signature of Patient Date