Medical Health

General Heath (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your Physician: _____
Are you presently under the care of a physician? ☐Yes ☐No
If yes, explain why? _____
_____

Are you currently taking any medication? ☐ Yes ☐ No
If yes, please list: _____
_____
_____

Are you allergic to: ☐ Antibiotics ☐ Codeine ☐ Aspirin ☐ Local Anesthetics
Any other medications? _____

Have you ever been hospitalized? If so, list reasons & dates.
_____
_____

Have you had any blood transfusions? ☐Yes ☐No
Do you smoke cigarettes? ☐Yes ☐No
Do you consume alcohol daily? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No
Is your blood pressure …. ☐ Normal ☐ Low ☐ High
Women: Are you pregnant? ☐ Yes ☐ No
If yes; how far along? _____

Do you have or have you ever been informed that you have any of the following?

Chest Pains: ☐ Yes ☐ No
Heart Disease: ☐ Yes ☐ No
Heart Murmur: ☐ Yes ☐ No
Stroke: ☐ Yes ☐ No
Postural Hypotension (faint spells): ☐Yes ☐No
Hypertension: ☐Yes ☐No
Kidney Problems: ☐Yes ☐No
Congenital Heart Defects: ☐Yes ☐No

Do you have a history of cold sores, fever blister, or canker sores? ☐Yes ☐No
Are you being treated with immunosuppressive drugs? ☐Yes ☐No
Have you ever used drugs for recreational purposes? ☐Yes ☐No

Please Check All That Appy:

☐ AIDS / HIV Positive	☐ Allergies	☐ Anemia
☐ Arthritis/Gout	☐ Artificial Heart Valve	☐ Artificial Joint
☐ Asthma	☐ Blood Disease	☐ Breathing Problems
☐ Bruise Easily	☐ Cancer	☐ Chemotherapy
☐ Convulsions	☐ Diabetes	☐ Drug Addiction
☐ Easily Winded	☐ Eating Disorder	☐ Epilepsy or Seizures
☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting Spells or Dizziness
☐ Frequent Cough	☐ Frequent Diarrhea	☐ Frequent Headaches
☐ Glaucoma	☐ Heart Attack / Failure	☐ Heart Pacemaker
☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B or C
☐ Herpes	☐ High Cholesterol	☐ Irregular Heartbeat
☐ Liver Disease	☐ Lung Disease	☐ Mitral Valve Prolapse
☐ Osteoporosis	☐ Pain in Jaw Joints	☐ Psychiatric Care
☐ Radiation Treatments	☐ Renal Dialysis	☐ Rheumatic Fever
☐ Rheumatism	☐ Scarlet Fever	☐ Shingles
☐ Sickle Cell Disease	☐ Sinus Trouble	☐ Sleep Apnea / CPAP
☐ Spina Bifida	☐ Tonsillitis	☐ Stomach/Intestinal Disease
☐ Swelling of Limbs	☐ Thyroid Disease	☐ Tuberculosis
☐ Tumors or Growths	☐ Ulcers	

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes; _____
_____

Consent:

The undersigned hereby authorizes Dr. Renee Biondo to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patients' dental needs including x-rays, study models, photographs, medications, and the use of local anesthetic agents.

Patient Signature (Parent of Child) Date

Dental Health

When was your last dental visit? _____

Are you apprehensive (nervous) about your dental treatment? ☐ Yes ☐ No

If yes- have you ever had: ☐ Nitrous Oxide ☐ Medication prior to treatment

Have you ever had any serious problems with previous dental treatment?

☐ Yes ☐ No If yes, explain: _____

How often do you brush your teeth? _____

How often do you floss? _____

Do you routinely use mouth rinse? ☐ Yes ☐ No How often? _____

What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

Do you gag easily? ☐ Yes ☐ No

Do you experience dry mouth? ☐ Yes ☐ No

Do your gums feel tender or swollen? ☐ Yes ☐ No

Do your gums bleed while brushing and/or flossing? ☐ Yes ☐ No

Are you experiencing any pain or sensitivity? ☐ Yes ☐ No

Are any of your teeth sensitive to air or during chewing? ☐ Yes ☐ No

Do you chew on only one side of your mouth? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Do you clench/grind your teeth while sleeping or during the day? ☐ Yes ☐ No

Do your facial muscles ever feel tired? ☐ Yes ☐ No

Do you wear full dentures? ☐ Upper ☐ Lower ..... ☐ Yes ☐ No

Do you wear partial dentures? ☐ Upper ☐ Lower ..... ☐ Yes ☐ No

Do you have retention problems with your dentures? ☐ Yes ☐ No

Have you had any dental x-rays in the last five years? ☐ Yes ☐ No

Please add anything you feel is important: _____

_____

Smile DENTISTRY
with Dr. Renee Biondo

Date: _____

Name: _____

Date of Birth: _____ **Sex (circle)** M or F

Weight: _____ Height: _____

Home Address: _____

City: _____ Zip: _____ State: _____

Home Phone: _____ Cell: _____

Email Address: _____

Employer / Occupation: _____

Social Security Number (insurance purposes): _____

Marital Status (circle) SINGLE MARRIED WIDOWED DIVORCED

Spouse's Name: _____

Insurance:

Dental Insurance Company: _____

Policy Holder Name: _____

Employer: _____ Date of Birth: _____

Policy Holder Social Security Number: _____

Emergency Contact / Guardian of minor:

Name: _____

Phone Number: _____

Reason for your visit: _____

_____