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

Are you on a special diet? ☐ 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

Please Check All That Appy:

☐ Allergies	☐ Anemia	☐ Artificial Heart Valve	☐ Asthma	☐ Blood Disease	☐ Breathing Problems
☐ Bruise Easily	☐ Cancer	☐ Chemotherapy	☐ Convulsions	☐ Diabetes	☐ Eating Disorder
☐ Epilepsy/Seizures	☐ Excessive Bleeding	☐ Excessive Thirst	☐ Fainting Spells/Dizziness	☐ Frequent Cough	
☐ Frequent Diarrhea	☐ Frequent Headaches	☐ Hemophilia	☐ Hepatitis A	☐ Hepatitis B or C	
☐ Irregular Heartbeat	☐ Kidney Problems	☐ 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	☐ Spina Bifida	☐ Tonsillitis	☐ Stomach/Intestinal Disease		
☐ 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

smile DENTISTRY

with Dr. Renee Biondo

Date: _____ Name: _____

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

Home Address: _____ City: _____ Zip: _____

Social Security Number (insurance purposes): _____

Parent / Guardian's name: _____

Home Phone: _____ Cell: _____

Email Address: _____

Insurance:

Dental Insurance Company: _____

Policy Holder's Name: _____ Employer/Occupation: _____

Policy Holder's Social Security Number **:** _____ Date of Birth: _____

Dental Health:

Reason for your visit**:** _____

_____

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 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

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

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

Please add anything you feel is important: _____

_____