



Center for Smile Enhancement . Michael S. Sudit, D.D.S. LLC

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MEDICAL AND DENTAL INFORMATION

Name _____ Date of Birth _____ Gender M F
Last First M.I.

Primary Physician _____ Physician's Phone _____ Date of last visit _____

What was the reason for that visit? _____

Current/previous Dentist _____ Dentist's Phone _____ Date of last visit _____

Please list the **Names and Phone Numbers** of other physicians/dentists that are currently providing care for you:

1. _____ 2. _____
3. _____ 4. _____

Have you been hospitalized in the past five years? Y N If yes, what was the reason? _____

Are you taking any **medications**? (Please include: Prescription, Over the counter, and Herbal) Y N
If yes, please provide the name, dosage, and condition for which they are taken

1. _____	Taken for _____	2. _____	Taken for _____
3. _____	Taken for _____	4. _____	Taken for _____
5. _____	Taken for _____	6. _____	Taken for _____
7. _____	Taken for _____	8. _____	Taken for _____

Are you currently taking **Bisphosphonate** drugs? (ie Fosamax, Aredia, Fometa, Actonel, Boniva, etc) Y N
If "yes" what is the medication? _____ dosage? _____ When/Why did you stop? _____

Are you **allergic** to, or have you had a reaction to any of the following? (If "yes", please provide details)

Aspirin	Y N _____	Penicillin	Y N _____
Ibuprofen (Advil)	Y N _____	Erythromycin	Y N _____
Codeine	Y N _____	Sulfa	Y N _____
Benzodiazepines (ie Valium)	Y N _____	Tetracycline	Y N _____
Latex	Y N _____	Local Anesthetics (ie Novocaine)	Y N _____
Jewelry	Y N _____	Metals	Y N _____
Food (ie peanuts)	Y N _____	Other _____	

Are you required to **Pre-Medicate with antibiotics before dental treatment**? Y N

If "yes", Reason: _____ Medication _____ Dosage _____

PAST AND CURRENT MEDICAL CONDITIONS (Please mark all that apply)

Abnormal bleeding.....	Y N	High Blood Pressure (BP: /).....	Y N
Anemia.....	Y N	High Cholesterol.....	Y N
Angina.....	Y N	Irregular Heartbeat.....	Y N
Arthritis.....	Y N	Kidney Disease (Dialysis Y N).....	Y N
Artificial Joint (Where:)(When:).....	Y N	Liver Disease (Including Jaundice).....	Y N
Asthma.....	Y N	Low Blood Pressure (BP: /).....	Y N
Autoimmune Disorder (type:).....	Y N	Migraine Headaches.....	Y N
Bleeding Disorder.....	Y N	Organ Transplant (Where: When:).....	Y N
Cancer (Type(s):).....	Y N	Pacemaker (When:).....	Y N
Chemical Dependency (Type:).....	Y N	Osteoporosis.....	Y N
Colitis.....	Y N	Previous Biopsies (Type:).....	Y N
Congenital Heart Defect / Disease.....	Y N	Psychiatric Problems/Treatment.....	Y N
Congestive Heart Failure.....	Y N	Radiation Therapy/Chemotherapy (When:).....	Y N
Chronic Obstructive Pulmonary Disease (COPD)....	Y N	Rheumatic Fever	Y N
Coumadin	Y N	Seizures.....	Y N
Depression.....	Y N	Sexually Transmitted Disease (Type:).....	Y N
Diabetes (Type:) (Controlled? Y N).....	Y N	Sleep Apnea/Dyspnea	Y N
Difficulty Breathing.....	Y N	Slow Healing Mouth Sores.....	Y N
Eating Disorder.....	Y N	Canker Sores.....	Y N
Emphysema.....	Y N	Stroke (When:).....	Y N
Epilepsy.....	Y N	Stomach Disorder (Type:).....	Y N
Fainting spells.....	Y N	Thyroid Disorder (Type:).....	Y N
Glaucoma.....	Y N	Tuberculosis.....	Y N
HIV- AIDS or ARC.....	Y N	Ulcers.....	Y N
Heart Attack (When:).....	Y N	Women: Pregnant?	Y N
Heart Surgery (When:).....	Y N	Women: Planning on becoming pregnant?	Y N
Heart Valve Replacement (When:).....	Y N	Women: Nursing?	Y N
Hepatitis (Type: A B C).....	Y N	Women: Oral Contraceptives?	Y N
		Other (Specify:).....	Y N

DENTAL INFORMATION

(If you answer "yes" to any of the following, please explain below)

1. Have you ever had an upsetting experience in a dental office?..... Y N
2. Is it important for you to keep your teeth?..... Y N
3. Are you dissatisfied with the appearance of your teeth?..... Y N
4. Are you dissatisfied with the function of your teeth?..... Y N
5. Is there anything about having dental treatment that bothers you?..... Y N
6. Does food tend to become caught between your teeth?..... Y N
7. Do your gums often bleed while brushing or flossing?..... Y N
8. Have you noticed any loosening of your teeth?..... Y N
9. Have you ever had an injury to your head, neck, or jaw?..... Y N
10. Do you clench or grind your teeth while asleep or awake?..... Y N
11. Do you bite your nails, lip, or cheeks frequently?..... Y N
12. Have you noticed any of the following with your jaw:

Clicking of the jaw?	Y N	Pain? (joint, ear, side of face)	Y N
Difficulty in opening or closing?	Y N	Difficulty in chewing?	Y N
13. Have you had orthodontic (braces) treatment?..... Y N
14. Have you had oral surgery?..... Y N
15. Have you had any periodontal (gum) treatment?..... Y N
16. Have you ever had your bite adjusted?..... Y N

- 17. Have you ever worn a bite plane, splint, or other appliance?.....Y N
- 18. Are you having dental pain at this time?.....Y N**
- 19. Do you supplement your diet with fluoride?.....Y N
- 20. Do you get frequent canker sores?.....Y N
- 21. Do you or have you been told that you snore?.....Y N If "yes", do you wear a CPAP?.....Y N
- 22. Do you have sensitive teeth?..... Y N If "yes", do you use a desensitizing toothpaste?.....Y N
- 23. Do you smoke?....Y N If "yes", how many packs per day? _____
- 24. Do you chew tobacco?... Y N If "yes", how often? _____
- 25. Do you drink soda?....Y N If "yes", with or with out sugar? _____ How often? _____

**Please provide an explanation if you answered "yes" to any of the above item
(Please explain any condition, disease, or problem not listed)**

Are you interested in or request additional information on any of the following:

- | | | | |
|----------------------------|-------|------------------------------|-------|
| Cosmetic dental procedures | _____ | Invisalign/Braces | _____ |
| Sealants | _____ | Botox | _____ |
| Veneers | _____ | Dermal Fillers (ie Juvederm) | _____ |
| Dental Implants | _____ | Medical Skin Care Products | _____ |
| Desensitizing Options | _____ | Teeth Whitening | _____ |
| Care Credit Financing | _____ | Other (please specify) | _____ |

To the best of my knowledge, the above information is complete and correct.

Signature of Patient or Guardian: _____ Date: _____

FOR OFFICE USE

Medical / Dental Health Update (please verify any changes in your health status and/or medications)

<u>Date</u>	<u>Change in Health</u>	<u>Change in Medication(s)</u>	<u>Signature</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

