Center for Smile Enhancement . Michael S. Sudit, D.D.S. LLC
10500 Wayzata Blvd. Minnetonka, MN 55305
(952) 593-9310

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

Date	Change in Health	Change in Medication(s)	Signature
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date	Change in Health	Change in Medication(s)	Signature