PROMENADE DENTAL - DENTAL / MEDICAL HISTORY

55 S. Main Street Suite 290 Naperville Illinois 60540 - 630-357-3333 – Smilesbydrgibson@gmail.com

Patient Name: ____

Please check any of the following problems that apply to you.	Yes	No
-Sensitivity (hot; cold, sweet, pressure)	■	■
Where? UR LR UL LL		
-Headaches, earaches, neck pain	■	■
-Jaw joint pain	■	■
-Teeth or fillings breaking	■	■
-Grinding or clenching teeth	■	■
-Bleeding, swollen or irritated gums	■	■
-Loose, tipped or shifting teeth	■	■
-Bad breath	■	■
Do you have or have you had any of the following?		
-Dentures	■	■
-Partial dentures	■	■
-Braces	■	■
-Periodontal (gum) treatments	■	■

Please share the following dates:

- Your last cleaning ___________________
- Your last oral cancer screening _______
- Your last complete X-Rays ___________

Name of Previous Dentist _______________________

City _________________ State ______________

Phone Number ____

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	■	■
Do you smoke or use chewing tobacco?	■	■
How much?_ For how long? _		
If I could change my smile, I would:		
-Make it whiter	■	■
-Make it straighter	■	■
-Close spaces	■	■
-Replace black metal fillings with tooth colored restorations	■	■
-Repair chipped teeth	■	■
-Replace missing teeth	■	■
-Replace old crowns that don't match	■	■
-Have a smile makeover	■	■

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist? ____________________________

What is the most important thing to you about your future smile and dental health? ____________________________

What is the most important thing to you about your dental visit today? ____________________________

MEDICAL HISTORY

Please check any of the following problems / conditions that apply to you:

	YES	NO
AIDS	■	■
Allergies (Seasonal)	■	■
Anemia	■	■
Angina (Chest pain)	■	■
Arthritis	■	■
Artificial Heart Valve	■	■
Artificial Joints	■	■
Asthma	■	■
Blood Disease	■	■
Bruise Easily	■	■
Cancer	■	■
Cervical Cancer	■	■
Chemotherapy	■	■
Cortisone Medication	■	■
Diabetes	■	■

	YES	NO
Dizziness	■	■
Drug Addiction	■	■
Emphysema	■	■
Epilepsy	■	■
Excessive Bleeding	■	■
Fainting	■	■
Glaucoma	■	■
Heart Conditions	■	■
Heart Lesions (Congenital)	■	■
Heart Murmur	■	■
Heart Surgery	■	■
Hepatitis A	■	■
Hepatitis B	■	■
Hepatitis C	■	■
High Blood Pressure	■	■

	YES	NO
HIV Positive	■	■
HPV (Human Papilloma Virus)	■	■
Jaundice Jaw	■	■
Joint Pain	■	■
Kidney Disease	■	■
Liver Disease	■	■
Low Blood Pressure	■	■
Mitral Valve Prolapse	■	■
Nervousness/Depression	■	■
Pacemaker	■	■
Pregnant Currently	■	■
Radiation (head/neck)	■	■
Respiratory Problems	■	■
Rheumatic Fever	■	■
Rheumatism	■	■

	YES	NO
Scarlet Fever	■	■
Seizures Sinus	■	■
Problems	■	■
Sleep Apnea	■	■
Stomach Problems	■	■
Stroke	■	■
Thyroid Disease	■	■
Tuberculosis	■	■
Ulcers	■	■
Venereal Diseases	■	■
Other _		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	■	■	Percodan	■	■	Tetracycline	■	■	Valium	■	■
Darvon	■	■	Latex	■	■	Codeine	■	■	Penicillin	■	■
Nitrous Oxide	■	■	Local Anesthetic	■	■	Erythromycin	■	■	Sulfa	■	■

Other _

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	■	■	Zometa	■	■
Aredia	■	■	Boniva	■	■
Fosamax	■	■	Herbal Supplements	■	■
Reclast	■	■			

Are you under a physician's care? What for?

____

What medications are you currently taking?

____

Family Physician Phone Number

____

Consent:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

______________________ ____________ ______________________

Patient Signature (Parent if child) **Date** **Dentist Signature**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I,___________________________________, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I,___________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}	Relationship
{Please Print Name}	Relationship
{Please Print Name}	Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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