

cont'd Medical History

Are you allergic to the following:

Y N Penicillin

Y N Aspirin

Y N Anesthetic

Y N Erythromycin

Y N Codeine

Y N Latex

List any other allergies _____

Is there anything else about your medical history you feel we should know? _____

In case of an emergency, nearest relative not living with you _____
name phone

Dental Health

Is there anything you feel we should know about any past dental treatment? _____

Is there anything your previous dental office did that you want us to do? _____

Is there anything you didn't like? _____

To make our patients comfortable we offer several amenities. Circle all that you would like.

nitrous oxide (laughing gas) music (type of music or artists) _____

neck pillow blanket lip balm electric back massager prescription medication

Smile Analysis

Are you unhappy with the overall appearance of your teeth, your smile? YES NO

Do you consider your teeth discolored, yellow or dark? YES NO

Would you like your teeth to be whiter? YES NO

Do you have any existing dental work you find unattractive? YES NO

If possible, what changes would you make to your smile? _____

The above information is correct to the best of my knowledge and I authorize the doctor and staff to provide dental services including photographic documentation for scientific and educational purposes. I assume responsibility for fees associated with all services provided.

Signature (Parent's signature if minor) _____