SILOAM SMILES

Dental Introduction

1. Is there anything about your smile you don't like? _____
2. Do you like the appearance of your teeth? _____
3. Are your teeth all in alignment (straight)? _____
4. Do you have any missing or chipped teeth? _____
5. Is your bite comfortable for chewing, biting? _____
6. Do you have frequent headaches? _____
7. Do you have any old fillings or dental work that you don't like? _____
8. What would you like to change the most in the appearance of your teeth? _____
9. If the 'Tooth Fairy' could grant you a dental wish, what would that be? _____

Dental History

1. Are you nervous about dental treatment? _____
2. If there any anything about your mouth that concerns you? _____
3. What type of toothbrush do you use?
   □ Soft □ Medium □ Hard
4. Do you use dental floss? _____ Toothpicks? _____
   How often? _____
5. Do your gums ever bleed? _____
6. Are any of your teeth mobile? (Tooth) _____
7. Do you have any swelling, sores or blisters in your mouth? _____
8. Have you ever been instructed on how to prevent tooth decay? _____
9. Have you ever been told that you have gum disease? _____
10. Do you smoke? _____ Chew tobacco? _____
11. Do you feel you have unpleasant breath at times? _____
12. How would you describe your dental health? _____

PLEASE CHECK IF YOU HAVE OR HAVE HAD THE FOLLOWING CONDITIONS:

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Fainting Spells	☐	☐	Pace Maker
☐	☐	Alcohol Abuse	☐	☐	Fever Blisters	☐	☐	Pneumonia
☐	☐	Anemia	☐	☐	Frequent Headaches	☐	☐	Psychiatric Problems
☐	☐	Angina Pectoris	☐	☐	Glaucoma	☐	☐	Radiation Therapy
☐	☐	Arthritis	☐	☐	Hay Fever	☐	☐	Rheumatic Fever
☐	☐	Artificial Joints	☐	☐	Heart Attack/Surgery	☐	☐	Seasonal Allergies
☐	☐	Artificial Valves	☐	☐	Heart Murmur	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Hemophilia	☐	☐	Shingles
☐	☐	Blood Transfusions	☐	☐	Hepatitis A	☐	☐	Shogren's Syndrome
☐	☐	Cancer-Chemotherapy	☐	☐	Hepatitis B	☐	☐	Sickle Cell Anemia
☐	☐	Colitis	☐	☐	Hepatitis C	☐	☐	Sinus Problems
☐	☐	Congenital Heart Defect	☐	☐	High Blood Pressure	☐	☐	Stroke
☐	☐	Cosmetic Surgery	☐	☐	HIV/AIDS	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	Kidney Problems	☐	☐	Tuberculosis
☐	☐	Difficulty Breathing	☐	☐	Liver Disease	☐	☐	Ulcers
☐	☐	Drug Abuse	☐	☐	Low Blood Pressure	☐	☐	Venereal Diseases
☐	☐	Emphysema	☐	☐	Lupus	☐	☐	Other (please list)
☐	☐	Epilepsy	☐	☐	Mitral Valve Prolaspe			

ALLERGIES:

Y	N	
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Milk

Other known allergies:

MEDICATIONS (PRESCRIPTION AND/OR OVER-THE-COUNTER): _____

IF FEMALE, PLEASE ANSWER THE FOLLOWING:

Y	N		Y	N		Y	N	
☐	☐	Birth Control	☐	☐	Pregnant, If yes, due date _____	☐	☐	Nursing

SIGNATURE: _____ DATE: _____

If under 18, Parent or Guardian Signature Required