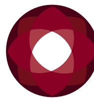

Santiago Dental Wellness

SEDATION. IMPLANTS. AESTHETICS.

DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet) ☐
  Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain ☐
- Mouth ulcers or cold sores ☐
- Teeth or fillings breaking ☐
- Grinding of 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 ☐
- 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** ________

Why did you leave your previous dentist? ______________________

____

Have you ever had/used Botox or dermal fillers? Y / N

Are you interested in anti-aging therapies? Y / N

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 my teeth whiter ☐
- Make my teeth straighter ☐
- Close spaces ☐
- Replace 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

What is the most important thing to you about your 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 that apply to you:

- ☐ Anemia
- ☐ Antibiotic Prophylaxis
- ☐ Arthritis
- ☐ Artificial Joint/Heart Valve
- ☐ Asthma
- ☐ Bisphosphonates
- ☐ Chemotherapy
- ☐ Chronic Pain
- ☐ Contact Lenses
- ☐ Depression/Anxiety
- ☐ Diabetes, HbAlc__________
- ☐ Dietary Supplements
- ☐ Dizziness/Fainting
- ☐ Drug/Alcohol Dependency
- ☐ Emphysema, Sarcoidosis
- ☐ Excessive Bleeding
- ☐ Fatigue/Exhaustion
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Heart Conditions (~6mos.)
- ☐ Heart Murmur
- ☐ Hepatitis (Type__________)
- ☐ High Cholesterol
- ☐ HIgh Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormone Deficiency
- ☐ Infective Endocarditis
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ MALE – prostate
- ☐ Migraines
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Psychiatric Treatment
- ☐ Radiation Therapy
- ☐ Respiratory Problems
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Smoking – now/previous
- ☐ Snoring
- ☐ Stroke (blood thinners)
- ☐ Take naps
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Viral Infections

For WOMEN Only

- ☐ Birth Control Pills
- ☐ Breast-feeding
- ☐ Pregnant
  Trimester__________

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Sulfa
- ☐ Other:
  ____
  ____
  ____
  ____

What Medications are you currently taking?

____

____

____

Are you being treated by a physician? Reason:

____

____

Family Physician __________ **Phone Number** __________

Patient: ______________________ Signature ______________________ Date __________

Doctor: ______________________ Signature ______________________ Date __________