WeCreateSmiles®
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Patient: _____ DOB:_____ Sex: M / F

Previous Dentist:_____ Date of last exam:_____

Are you happy with your smile: Y / N if no what would you like to change:_____

Please check if you have now or in the past had any of these dental problems:

☐ Bad breath ☐ Jaw pain or popping ☐ Sores in mouth

☐ Bleeding gums ☐ Sensitivity to temperature ☐ Loose fillings/crowns

Medical History:

Primary Care Physician: _____ Phone:_____

Have you had any serious injury or illness: Y / N if yes please explain:_____

Women: Are you pregnant? Y / N Nursing? Y / N Taking birth control pills? Y / N

Please check if you have now or in the past had any of these medical issues:

	AIDS/ HIV positive		Cough, persistent		Kidney Disease		Stroke
	Anaphylaxis		Cough up blood		Liver Disease		Surgical implant
	Anemia		Diabetes		Mitral Valve Prolapse		Swelling of ankles or feet
	Arthritis / Rheumatism		Epilepsy		Nervous Problems		Thyroid disease
	Artificial Heart Valves		Fainting		Pacemaker		Tobacco Habit
	Artificial Joints		Food Allergies		Heart Surgery		Tonsillitis
	Asthma		Glaucoma		Psychiatric Care		Tuberculosis
	Atopic (allergy prone)		Headaches		Rapid Weight loss or gain		Ulcer/ Colitis
	Back Problems		Heart murmur		Respiratory Disease		Venereal Disease
	Blood disease		Heart problems		Radiation Treatment		Any other issue not listed:
	Cancer		Abnormal bleeding		Rheumatic/ Scarlet Fever		_____
	Chemical dependency		Herpes		Shingles		_____
	Chemotherapy		Hepatitis		Shortness of breath		_____
	Circulatory problems		High Blood Pressure		Skin Rash		_____
	Cortisone Treatments		Jaw Pain		Spina Bifida		_____

Please list all current medications or attach a list:_____

_____

Please list all allergies: _____

I have reviewed the information on this questionnaire , and it is accurate to the best of my knowledge. I understand this information will be used to determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date:_____