SILVESTRI & COMFORT
FAMILY DENTISTRY

Patient Name: _____ Date: _____
Last First MI

Gender: _____ Marital Status: _____ Date of Birth: _____ Social Security #: _____

Phone: (home) _____ (work)_____ ext._____ (cell) _____

E-Mail Address: _____

How would you like your appointment confirmed? ☐ Email ☐ Cell Phone ☐ Work Phone ☐ Home Phone

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Dental History

Date of last dental visit: _____

(Please Circle) YES / NO Have you ever been told you need to pre-med or take antibiotics before a dental visit?
YES / NO Have you ever had a heart valve replacement or heart infection (endocarditis)?
YES / NO Are your teeth sensitive to hot or cold?
YES / NO Are your teeth sensitive to sweets or sour?
YES / NO Do you feel pain in any of your teeth?
YES / NO Do you have any sores or lumps in your mouth?
YES / NO Have you had any neck, head or jaw injuries?
YES / NO Do you have frequent headaches?
YES / NO Do you clench or grind your teeth?
YES / NO Do you bite your lips or cheeks frequently?
YES / NO Have you ever considered orthodontics?
YES / NO Have you ever had any orthodontic work done?

Have you ever experienced any of the following in your jaw? (Please Circle)

YES / NO Clicking / Popping YES / NO Pain (Joint, Ear, Face)
YES / NO Difficulty opening / closing YES / NO Difficulty Chewing

On a scale of 1-10, (1= Unhappy 10=Happy), how would you rate these:

Are you happy with your smile? 1 2 3 4 5 6 7 8 9 10
Do you feel your teeth are white enough? 1 2 3 4 5 6 7 8 9 10
How important are your teeth to you? 1 2 3 4 5 6 7 8 9 10

What would you change about your smile? _____

Is there anything else about having dental treatment you would like us to know? _____

_____

_____

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

Medical History

Are you under the care of a physician? YES / NO

Physician Name:_____Office Phone: _____

Date of last physical exam: _____

Please list ALL Prescription and non Prescription Medications you are currently taking: _____

_____

Allergies / Sensitivities (please Circle)

YES / NO Penicillin / Other Antibiotics
YES / NO Latex
YES / NO Sulfa Drugs
YES / NO Iodine
YES / NO Sedatives, Barbiturates, Sleeping Pills
YES / NO Aspirin
YES / NO Codeine / Other Narcotics
YES / NO Any Metals
YES / NO Other (please list) _____

Do you have, or have you had, any of the following? (please Circle)

YES / NO AIDS/HIV Positive
YES / NO Anemia
YES / NO Angina
YES / NO Arthritis/Gout
YES / NO Artificial Heart Valve
YES / NO Artificial Joints
YES / NO Asthma
YES / NO Blood Disease
YES / NO Cancer
YES / NO Chemotherapy/Radiation Treatment
YES / NO Chest Pains
YES / NO Congenital Heart Disorder
YES / NO Diabetes
YES / NO Drug Addiction
YES / NO Emphysema
YES / NO Epilepsy or Seizures
YES / NO Fainting Spells/Dizziness
YES / NO Glaucoma
YES / NO Hay Fever
YES / NO Heart Attack/Failure
YES / NO Heart Murmur
YES / NO Heart Pacemaker
YES / NO Heart Trouble/Disease
YES / NO Hepatitis
YES / NO High or Low Blood Pressure
YES / NO Hypoglycemia
YES / NO Intestinal Disease/Ulcers
YES / NO Kidney Problems
YES / NO Liver Disease
YES / NO Lung Disease
YES / NO Mitral Valve Prolapse
YES / NO Rheumatic Fever
YES / NO Rheumatism
YES / NO Sexually Transmitted Disease
YES / NO Stroke
YES / NO Swelling of Limbs
YES / NO Thyroid Disease
YES / NO Tuberculosis
YES / NO Tumors or Growths

All (please Circle)

YES / NO Do you smoke or use any tobacco products?

Women (please Circle)

YES / NO Do you take Bisphosphonate Meds (Fosomax, Actonal, Didracal,etc.)

YES / NO Do you take Birth Control Pills / Hormone Therapy Pills?

YES / NO Are you pregnant?

YES / NO Are You nursing?

To the best of my knowledge all of the preceding answers and information provided are true and correct.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian