

**Other Information**

Date of Last Dental Visit: \_\_\_\_\_

Are you having DENTAL PROBLEMS now? \_\_\_\_\_

Would you like your smile to LOOK BETTER or DIFFERENT?

If yes, please explain \_\_\_\_\_

Do you use tobacco products? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

Do you consume alcoholic beverages?

If yes, please explain. \_\_\_\_\_

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

\_\_\_ Heart Disease or Attack \_\_\_ Angina Pectoris \_\_\_ High Blood Pressure

\_\_\_ Heart Murmur \_\_\_ Rheumatic Fever \_\_\_ Artificial Heart Valve

\_\_\_ Heart Pacemaker \_\_\_ Heart Surgery \_\_\_ Artificial Joints

\_\_\_ Anemia \_\_\_ Stroke \_\_\_ Hepatitis

\_\_\_ Bleeding Problems \_\_\_ Epilepsy/Seizures \_\_\_ Glaucoma

\_\_\_ Chemotherapy \_\_\_ Venereal Disease \_\_\_ Bruise Easily

\_\_\_ Allergies or Hives \_\_\_ Diabetes \_\_\_ Thyroid Disease

\_\_\_ Radiation Treatment \_\_\_ Ulcers \_\_\_ Alcoholism

What MEDICATIONS are you currently taking? \_\_\_\_\_

Additional medications: \_\_\_\_\_

Are you allergic to any of the following medications?

\_\_\_ Aspirin \_\_\_ Local Anesthetic \_\_\_ Penicillin/Amoxicillin

\_\_\_ Latex \_\_\_ Codiene \_\_\_ Erythromycin

Are you aware of being allergic to any other medications or substance?

\_\_\_\_\_