

Date: _____

Melani Kapetanakos, DDS

Name (Last) (First) (Middle) / / M F S M D W
Date of Birth Sex Marital Status Social Security Number

Home Address (Street) (City) (State) (Zip Code) Home Phone Number

Cell Phone Number E-Mail Address Name of Employer

Business Address (Street) (City) (State) (Zip Code) Business Phone Number

Medical History

General health (please circle): EXCELLENT GOOD FAIR POOR Name of physician _____

Physician's address _____ Telephone number _____ Date of last physical _____

Are you pregnant/ nursing.....Y N If yes, expected delivery date: _____

Are you taking birth control pills?.....Y N

Do you smoke?.....Y N If yes, how much? _____

Are you allergic to any medications?.....Y N If yes, names of medications _____

Are you taking any medication now?.....Y N If yes, names of medications and problems for which they are taken:

Medication 1) _____ Taken for _____ 3) _____
2) _____ 4) _____

Have you ever experienced the following medical problems? (please circle appropriate answer):

Heart disease.....Y N	Cancer.....Y N
Rheumatic fever/Scarlet fever.....Y N	Mitral valve prolapse.....Y N
Abnormal blood pressure.....High Low Norm	Heart murmur.....Y N
Steroid Therapy.....Y N	Pacemaker.....Y N
Tuberculosis or lung disease.....Y N	Jaundice.....Y N
Diabetes.....Y N	Ulcers.....Y N
Epilepsy.....Y N	Asthma or hay fever.....Y N
Anemia.....Y N	Sinus trouble.....Y N
Congenital heart lesions.....Y N	Hepatitis.....Y N
Arthritis.....Y N	Radiation treatments.....Y N
Lymph node enlargement (swollen glands).....Y N	Seizures.....Y N
Artificial joints/valves.....Y N	Persistent diarrhea.....Y N
Sickle Cell Disease.....Y N	Stroke.....Y N
Abnormal bleeding.....Y N	Thyroid Disease.....Y N
Excessive urination and/or thirst.....Y N	Emphysema.....Y N
Kidney problems.....Y N	Liver Disease.....Y N

If you have entered "yes" to any of the above, please explain: _____

Have you been hospitalized for any reason? If so, explain: _____

Dental Health

Reason for visit: _____ Approximate date of last dental visit: _____

Have you ever had any serious problem associated with previous dental treatment? Y N

If so, explain: _____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____

Do you avoid brushing any part of your mouth because of pain? Y N If yes, what part? _____

Which foods cause you twinges of pain? hot cold sweet sour none

Do you chew on only one side of your mouth? Y N

Do your gums bleed? Y N

Do you clench or grind your jaws while sleeping or during the day? Y N

How did you hear of Bayside Smile Design and Dental Spa? _____

I affirm that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I respect that 24 hours notice is required for any changes in scheduling or there will be a \$40 broken appointment fee.

Patient: _____
Signature Date

If patient is LESS THAN 18 YEARS OLD, parent or legal guardian MUST sign above.

Cosmetic/Esthetic Evaluation

Reason for cosmetic consult? _____ Have you had a cosmetic consult before:? Y N

Would you like to have whiter teeth? Y N Have you used dental whitening products? Y N Which ones? _____

If you had a *magic wand* what, if anything, would you change about your smile? _____

Do you have any *special* occasions coming up?

What specifically would you like to change about your smile?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> replace missing teeth | <input type="checkbox"/> Rebuild fracture(s) | <input type="checkbox"/> Straighten rotation/angulation | <input type="checkbox"/> Eliminate dark/stained fillings |
| <input type="checkbox"/> implants | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Gum lengthening | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____
Doctor's Comments:

