

# SILVESTRI DENTAL & Associates

*Extraordinary Care, Extraordinary Smiles*

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: \_\_\_\_\_

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## 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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

### 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 Are you pregnant?
YES / NO Do you take Birth Control Pills / Hormone Therapy Pills?	YES / NO Are You nursing?

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

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