HONOLULU
SMILE DESIGN
1481 S. King St. Suite 303
Honolulu, HI 96814
(808) 941-2088

Date_____

How would you prefer to be contacted for appointment confirmations?
☐ call ☐ text ☐ email

Patient Information

Patient's Last Name | First | Middle Initial | Sex | Marital Status

What name would you like to be called by in our office? | Date of Birth | Age | Social Security Number

Mailing Address | City | State | Zip | Home Telephone Number

Residence Address | City | State | Zip | Business Telephone Number

Additional Contact information: email:_____ Cell Phone:_____

Occupation | Employer | Second Occupation | Second Employer

Who may we thank for referring you to our office?_____

Spouse/Responsible Party Information

Spouse or Responsible Party Last Name | First | Middle Initial | Social Security Number

Mailing Address | City | State | Zip | Home Telephone Number

Occupation | Employer | Date of Birth | Business Telephone Number

Emergency Contact Last Name | First | Middle Initial | Relationship to Patient

Mailing Address | City | State | Zip | Home Telephone Number

Dental Insurance Information-Primary Coverage

Insured's Name | Insured's Employer | Social Security Number

Insurance Company Name | Address | City | State | Zip

Membership/Group/Plan Numbers | Insurance Effective Date

Dental Insurance Information-Secondary Coverage

Insured's Name | Insured's Employer | Social Security Number

Insurance Company Name | Address | City | State | Zip

Membership/Group/Plan Numbers | Insurance Effective Date

Signature:_____

Patient, Parent or Guardian **Date**

Dental History

What is your reason for today's visit?_____

When was your last dental visit?_____ When was your last dental cleaning?_____

(Please check the appropriate box)	YES	NO
Are you interested in services that may save you money?	☐	☐
Are you apprehensive or anxious about dental treatment?	☐	☐
Are you experiencing dental pain now?	☐	☐

If so, where?_____

Has any medical doctor advised you to take pre-medication prior to dental care? ☐ ☐

If yes, please describe:_____

(Please check the appropriate box)	YES	NO
Do you brush your teeth at least twice a day?	☐	☐
Do you floss?	☐	☐
If yes, how many times a week?_____		
Do you have frequent headaches?	☐	☐
Do you smoke or chew tobacco?	☐	☐
Does your breath concern you?	☐	☐
Do you avoid brushing or flossing due to pain?	☐	☐
Do your gums bleed while brushing or flossing?	☐	☐
Have you noticed any loosening of your teeth?	☐	☐
Does food tend to become caught between your teeth?	☐	☐
Have you ever had sores or lumps in or near your mouth?	☐	☐
Have you ever experienced any of the following problems with your jaw?		
a. Clicking, popping, or locking?	☐	☐
b. Pain (joint, ear, side of face)?	☐	☐
c. Difficulty in opening or closing?	☐	☐
d. Difficulty in chewing?	☐	☐

	YES	NO
Do you clench or grind your teeth while while asleep or awake?	☐	☐
Do you have frequent headaches, neckaches, or migraines?	☐	☐
Do you have any pain in or around your ears?	☐	☐
Have you ever had any head, neck, or jaw injuries?	☐	☐
Do you wear any type of retainer, nightguard or removable oral appliance?	☐	☐
If yes, describe:_____		
Do you snore?	☐	☐
Have you ever taken a sleep test?	☐	☐
Have you been diagnosed with sleep apnea?	☐	☐
Have you worn a CPAP for sleep apnea?	☐	☐
If yes, was it comfortable for you?	☐	☐
If no, describe:_____		

(Please check the appropriate box)	YES	NO
Are you happy with the appearance of your smile?	☐	☐
Are you happy with the color of your teeth?	☐	☐
Have you ever whitened your teeth?	☐	☐
Have you noticed any spaces or gaps between your teeth?	☐	☐
Have you had braces or orthodontics before?	☐	☐
If so when?_____		
Have you thought about straightening your teeth?	☐	☐

	YES	NO
Are you happy with the length or shape of your teeth?	☐	☐
Do you have missing teeth that you would like to have replaced?	☐	☐
If you could change anything about you smile, what would you change and why?_____		

PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

NAME:_____ **DATE OF BIRTH:**_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

Physician's Name:_____ Phone Number:_____

Address:_____ When was your last physical?_____

(Please check the appropriate box)	**YES**	**NO**
Are you in good health?	☐	☐
Has there been any changes in your general health within the past year?	☐	☐
Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
If yes, please explain:_____		
Are you under the care of a physician?	☐	☐
If yes, please describe:_____		
Have you ever required a blood transfusion?	☐	☐
Do you bruise easily?	☐	☐
Have you had any abnormal bleeding?	☐	☐
Have you had a recent weight loss?	☐	☐
Do you use tobacco products in any form?	☐	☐
Do you use alcohol?	☐	☐
Do you use any recreational drugs?	☐	☐
Have you ever taken Bisphosphonates or medicine for osteoporosis and bones?	☐	☐
Have you ever taken methotrexate or medicine for cancer or rheumatism?	☐	☐
Women only: (three questions below)		
Are you pregnant or think you may be?	☐	☐
Are you nursing?	☐	☐
Are you taking birth control pills?	☐	☐

	YES	**NO**
Are you taking any medication(s)?	☐	☐
Including non-prescription medicine?	☐	☐

If yes, please list below and be specific (if possible):

_____

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Are you allergic to or have you had reactions to:

	YES	**NO**
Local anesthetics like Novocain or Epinephrine	☐	☐
Penicillin, Erythromycin, or other antibiotics?	☐	☐
Sulfa drugs?	☐	☐
Barbiturates, sedatives or sleeping pills?	☐	☐
Aspirin?	☐	☐
Iodine?	☐	☐

	YES	**NO**
Latex (have you reacted to blowing up balloons or are you unable to wear band aides)?	☐	☐
Other?	☐	☐

If yes, please describe:_____

_____

_____

PATIENT CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE

Do you have or have you ever had the following:

	YES	NO		YES	NO
Artificial Valves or Stents?	☐	☐	Chemotherapy or radiation therapy?	☐	☐
Congenital Heart Disease?	☐	☐	Prolonged Cough 4 or more weeks?	☐	☐
Heart Defect or heart murmur?	☐	☐	Coughing blood?	☐	☐
Heart trouble, heart attack or angina?	☐	☐	Vertigo?	☐	☐
Pacemaker?	☐	☐	Unexplained weight loss?	☐	☐
Heart Surgery?	☐	☐	Tuberculosis?	☐	☐
High Blood Pressure?	☐	☐	Sinus trouble?	☐	☐
Low Blood Pressure?	☐	☐	Lung or breathing problems?	☐	☐
Hepatitis, jaundice or liver disease?	☐	☐	Asthma or hay fever?	☐	☐
Stroke?	☐	☐	Hives or skin rash?	☐	☐
Cancer?	☐	☐	Allergies?	☐	☐
Diabetes?	☐	☐	Fainting spells, dizziness, or seizures?	☐	☐
HIV/AIDS?	☐	☐	STD's?	☐	☐
Thyroid problems?	☐	☐	Arthritis or rheumatism?	☐	☐
Kidney trouble?	☐	☐	Joint replacement or implant?	☐	☐
Stomach ulcer?	☐	☐	Epilepsy?	☐	☐
Leukemia?	☐	☐	Anemia?	☐	☐
Glaucoma?	☐	☐	Any other medical problems?	☐	☐

I certify that the information listed is complete and accurate.

Signature: _____

Patient, Parent or Guardian **Date**

Medical History Update:

Date	**Comments**