Bel Air Smile Partners
2018 Rock Spring Road
Forest Hill, Maryland 21050
410.879.4444 P 410.893.1223 F

Smile Partners of Havre De Grace
333 Green Street
Havre De Grace, Maryland 21078
410.939.4030 P 410.939.3863 F

MEDICAL HISTORY

Today's Date

Last Name

First Name

Birthdate

Phone

Name of Medical Doctor

Phone

Emergency Contact

Phone

Relationship

List all medications that you are now taking

Are you allergic to any of the following?

Y	N	
☐	☐	Anesthetic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Ibuprofen
☐	☐	Latex
☐	☐	Acrylic
☐	☐	Penicillin
☐	☐	Iodine
☐	☐	Metals
☐	☐	Food or Food Coloring
☐	☐	Animals
☐	☐	Other

If Other, Please Explain

Heart and Circulation
Do you have a history of any of the following?

Y	N	
☐	☐	Pacemaker
☐	☐	High Blood Pressure
☐	☐	Excessive Bleeding
☐	☐	Stroke or TIA
☐	☐	Artificial Heart Valves
☐	☐	Anemia
☐	☐	Heart Murmur
☐	☐	Heart Attack
☐	☐	Low Blood Pressure
☐	☐	Congential Heart Defects
☐	☐	Chest Pains or Angina
☐	☐	Endocarditis
☐	☐	Abnormal Heart Condition

If Other, Please Explain

Ear, Nose, and Throat
Do you have a history of any of the following?

Y	N	
☐	☐	Sinus Troubles, Chronic Infection
☐	☐	Influenza, Pneumonia, Mononucleosis
☐	☐	Tonsil or Adenoid Condition
☐	☐	Frequent Ear or Throat Infections
☐	☐	Sleep Apnea
☐	☐	Difficulty Breathing
☐	☐	Asthma
☐	☐	Other Breathing or Respiratory Problems

If Other, Please Explain

Neurologic
Do you have a history of:

Y	N	
☐	☐	Seizure Disorder or Epilepsy
☐	☐	Physical Handicap
☐	☐	Genetic Birth Defect
☐	☐	Brain Injury or Trauma
☐	☐	Mental Illness or Disturbance
☐	☐	Other Neurological Condition

If Other, Please Explain

Infectious Disease
Do you have a History of:

Y	N	
☐	☐	Sexually Transmitted Disease
☐	☐	Human Papiloma Virus (HPV)
☐	☐	Body Piercings other than your Ears
☐	☐	Tuberculosis
☐	☐	Jaundice or Hepatitis
☐	☐	Herpes, Cold Sores, or Canker Sores
☐	☐	AIDS or HIV Infection
☐	☐	Tattoos
☐	☐	Organ Transplant or Blood Transfusion

If Other, Please Explain

Other Conditions
Do you have a History of:

Y	N	
☐	☐	Arthritis
☐	☐	Liver Disease
☐	☐	Alcoholism
☐	☐	Drug use/Addiction
☐	☐	Cancer
☐	☐	Bisphosphonate or Osteoporosis Drugs
☐	☐	Kidney Disease
☐	☐	Endocrine or Thyroid Condition
☐	☐	Eating Disorder
☐	☐	Diabetes
☐	☐	Hip or Joint Replacement
☐	☐	Radiation or Chemotherapy Treatment
☐	☐	Immunodefiency
☐	☐	Digestive Disorder

☐ ☐ Tobacco use/ smoking or chewing

☐ ☐ Frequent Headaches or Migraines

☐ ☐ Any other medical conditions, surgeries, or hospitalizations? What?

If Other, Please Explain

Y N

☐ ☐ Do you have a medical condition that you would like to discuss Privately with the Doctor?

WOMEN ONLY

Y N

☐ ☐ Are you on Birth Control

☐ ☐ Are you Pregnant

Dental History

Y N

☐ ☐ Any Injuries to face, head or neck

☐ ☐ Have you had Permanent or Extra Teeth Removed

☐ ☐ Any Extra Teeth or Congentially Missing Teeth

☐ ☐ Any Retained Primary (Baby Teeth

☐ ☐ Chipped or Injured Permanent Teeth

☐ ☐ Mobile or Loose Permanent Teeth

☐ ☐ Currently Sensitive or Sore Teeth

☐ ☐ Bleeding or Sore Gums

☐ ☐ History of Gum Disease

☐ ☐ Bad Breath or Bad Taste in Mouth

☐ ☐ Previous Tooth Infections, Pulpotomies, or Root Canals

☐ ☐ Frequent mouth sores, canker sore, or cold sores

☐ ☐ Food Impaction between the teeth

☐ ☐ Broken Teeth or Missing Fillings

☐ ☐ Tooth Grinding or Clenching

☐ ☐ Clicking, locking or pain in the jaw when opening or closing

☐ ☐ History of Treatment for TMJ or TMD Disorders

☐ ☐ Abnormal Swallowing or Tongue Thrust or Speech Issues

☐ ☐ Frequent Oral Habits (finger or thumb sucking, nail biting)

☐ ☐ Frequent Mouth Breathing, Snoring or Dry Mouth

☐ ☐ Any Orthodontic Concerns

☐ ☐ Previous Orthodontic Treatment or Consultation

Please Explain, if necessary

Adult Only Dental Questions
Please check all that apply

- ☐ Are you Anxious when you go to the Dentist?
- ☐ Have you had previous problems or poor experiences at the dentist?
- ☐ Would you prefer to be sedated for dental prodedures?
- ☐ Would you like to change anything about your smile?
- ☐ Would you like whiter teeth?
- ☐ Would you like to replace missing teeth?
- ☐ Would you like to remove stains/spots on teeth?
- ☐ Would you like to straighten your teeth?
- ☐ Would you like to close spaces between your teeth?
- ☐ Would you like to replace old crowns or fillings(silver or stained)?
- ☐ Would you like to reduce the amount of gum showing?
- ☐ Would you like to reduce the amount of tooth showing?
- ☐ Would you like to fix chipped or worn down teeth?
- ☐ Would you like to reshape/resize your teeth?

Please Explain, if necessary

Children Only
Please check all that apply

- ☐ Is this your child's first visit to the dentist?
- ☐ Any problems or poor experinces with previous dental visits?
- ☐ Previous use of Premedication, Twlight sleep, or General Anesthesia?
- ☐ Vision,hearing, special schooling problems
- ☐ Well Water
- ☐ City Water

Please Explain, if necessary

I certify that the above information is true to the best of my knowledge.
I authorize Bel Air Smile Partners staff and dentists to perform all necessary
dental procedures as mutally diagnosed and discussed with my dentist after examination.

Patient or Guardian's Signature

Doctor's Signature