

**WAKIM
Family & Cosmetic
DENTISTRY**

Smile Evaluation

Hold a full-face mirror 12" to 14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions.

Do you like the appearance of your teeth and your smile? Yes No
If not, explain _____

Are your teeth all in alignment (straight)? Yes No
If not, explain _____

Do you like the color of your teeth? Yes No
If not, explain _____

Do you like the shape of your teeth? Yes No

Are your teeth; chipped _____ protruding _____ hidden _____
If not, explain _____

Do you like the way your teeth come together? Yes No
If not, explain _____

Are there old fillings or dental work that you don't like looking at? Yes No
If yes, explain _____

Do your gums ever bleed when brushing or flossing? Yes No

Do you wish your teeth could be whiter? Yes No

What would you like to change most in the appearance of your teeth?

Why did you leave your last dentist? _____

How long has it been since you've been to a dentist? _____

What are you looking for in a dental office? _____

Email Address _____

Please fill out both sides of this form, thanks.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive Alzheimer's Disease Anaphylaxis Anemia Angina Arthritis/Gout Artificial Heart Valve Artificial Joint Asthma Blood Disease Blood Transfusion Breathing Problem Bruise Easily Cancer Chemotherapy Chest Pains Cold Sores/Fever Blisters Congenital Heart Disorder Convulsions Cortisone Medicine Diabetes Drug Addiction Easily Winded Emphysema Epilepsy or Seizures Excessive Bleeding Excessive Thirst Fainting Spells/Dizziness Frequent Cough Frequent Diarrhea Frequent Headaches Genital Herpes Glaucoma Hay Fever Heart Attack/Failure Heart Murmur Heart Pace Maker Heart Trouble/Disease Hemophilia Hepatitis A Hepatitis B or C Herpes High Blood Pressure Hives or Rash Hypoglycemia Irregular Heartbeat Kidney Problems Leukemia Liver Disease Low Blood Pressure Lung Disease Mitral Valve Prolapse Pain in Jaw Joints Parathyroid Disease Psychiatric Care Radiation Treatments Recent Weight Loss Renal Dialysis Rheumatic Fever Rheumatism Scarlet Fever Shingles Sickle Cell Disease Sinus Trouble Spina Bifida Stomach/Intestinal Disease Stroke Swelling of Limbs Thyroid Disease Tonsillitis Tuberculosis Tumors or Growths Ulcers Venereal Disease Yellow Jaundice

Have you ever had any serious illness not listed above? If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____