Designing Smiles
MEDICAL HISTORY

Patient Name	**Health Alert**	**DOB**

1. Have you been under the care of a medical doctor during the past 2 years? ……Yes No
   If yes, for what? _____
   Physician's Name _____Phone _____
2. Have you taken any medication/drugs during the past 2 years? ……Yes No
3. Please list any medication, drugs/pills you are taking: _____
   _____
4. Are you allergic to: (circle)
   Penicillin Erythromycin Codeine Latex Local Anesthetic Other: _____
5. Which of the following have you had, or do have presently? Please circle all that apply.

Rheumatic fever	chemical dependency	heart problems	kidney problems
Heart murmur	alcohol abuse	artificial joint/valves	glaucoma
Major surgery	recreational drug use	epilepsy/seizures	thyroid disease
Blood transfusion	asthma or lung disease	bleeding problems	eating disorders
Hepatitis	radiation therapy	liver problems	nervousness
Cancer	tuberculosis (+TB test)	diabetes	depression
Stroke	AIDS or HIV +	high blood pressure	anemia
Psychiatric treatment	fainting/dizziness	ulcers	sinus trouble
Neurological disorders	cold sores/fever blister	arthritis	

6. Please list any disease, condition, or problem not listed above: _____
7. ***Women*** *(please circle is applicable):* Pregnant/Trying Nursing Taking Oral Contraceptives

Patient/Guardian Signature _____ Date _____

Date:		Patient Signature: _____
BP:	No Changes	DDS/RDH Signature: _____
Date:		Patient Signature: _____
BP:	No Changes	DDS/RDH Signature: _____
Date:		Patient Signature: _____
BP:	No Changes	DDS/RDH Signature: _____
Date:		Patient Signature: _____
BP:	No Changes	DDS/RDH Signature: _____
Date:		Patient Signature: _____
BP:	No Changes	DDS/RDH Signature: _____

Designing Smiles
DENTAL HISTORY

Patient Name	**Health Alert**	**DOB**

Welcome to Designing Smiles!

What can we do for you today? _____

Do you have any specific concerns or anything that bothers you about your mouth? Yes No
If yes, please describe:
_____

Last Dental Visit_____ Last Dental Cleaning _____ Last Full Mouth x-rays_____

What was done at your last dental visit? _____

Describe your daily mouth care routine: _____

_____

_____

What other dental aids do you use? (electric t.b., rinses, special tooth pastes, etc.) _____

_____

Are any of your teeth sensitive to: (circle)

Hot Cold Sweets Biting

Do you have a bad taste in your mouth? …. …….Yes No
Do you frequently get cold sores,
blisters or any other oral lesions? ……...Yes No
Any sores or bumps that are not healing? ..... …..Yes No
Are you aware of clenching and grinding? ……Yes No
What kinds of sweet and sour foods do you have on a daily basis? _____

Do you:
Mouth-breathe while awake or asleep? ….....Yes No
Smoke/ chew tobacco? …….....Yes No
How much/ what age start/ how long _____
Feel nervous about dental treatment ……..Yes No
Ever had an unpleasant dental experience? ……..Yes No
If so, please describe: _____

_____

_____

Have you ever had:
Orthodontic treatment? ……Yes No
Periodontal Treatment? ……Yes No
A splint or mouth guard? ……Yes No
A serious injury to the mouth or head? ……..Yes No
If so, please describe, including cause: _____
_____

Do you have:
Difficulty chewing on either side of mouth? …...Yes No
Headaches, neck aches, or shoulder aches? ……...Yes No
Tired jaw, especially in the morning? ……..Yes No

Is there anything else about having dental treatment that you would like us to know or any concerns for the doctor today?
Yes No
If yes, please describe: _____
_____

_____

Are you happy with the appearance of your teeth/gums/smile? ……Yes No

Would you like to discuss enhancing the appearance of your smile? ……....Yes No

Are you interested in: (circle) Invisalign® Whitening Lumineers®/Veneers

WELCOME TO DESIGNING SMILES

Name (Last, First, MI)/ Preferred Name: _____ Sex M/F

Address: _____ City, State, Zip: _____

DOB: _____ SS#: _____

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

Contact Information:	May we contact:
Home Phone: _____	☐ Yes ☐ No
Cell Phone: _____	☐ Yes ☐ No
Work Phone: _____	☐ Yes ☐ No
E-mail Address: _____	☐ Yes ☐ No

Medical Records Release
I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. Designing Smiles receives medical information on patients that may need to be shared with medical providers. ☐ Yes ☐ No Initials _____

Treatment Authorization for a child/minor
If a parent or guardian is unable to be present for treatment to be performed, I authorize the staff at Designing Smiles to perform the necessary procedures as agreed upon per verbal or written consent. ☐ Yes ☐ No Initials _____

Photo Release
I, hereby release pictures of myself (or my child) taken by Designing Smiles for promotional purposes and materials including the Designing Smiles website. ☐ Yes ☐ No Initials _____

By signing this form, you are assuming responsibility for all charges regardless of insurance coverage.

Patient/Parent/Guardian Authorization: _____ Date: _____

Designing Smiles, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO PATIENT – PLEASE READ CAREFULLY

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activity, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of the other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Designing Smiles

2860 Snelling Avenue N. Suite # 1
Roseville, Mn 55113
651-636-2143

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat your or to continue treating your if you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this consent form and your notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____