Dr. Bard J. Levey
THE LATEST IN DENTISTRY
FROM PEOPLE WHO CARE
youramazingsmile.com

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1) Health History
2) Dental History
3) (optional) Cosmetic Dentistry Questionnaire

Health History

Date:

Name Social Security # (for insurance purposes)

Phone(Home) Cell

Work

Home Address

City State

Zip

Email Address

Date of Birth

Marital Status

Physician's Name and Number

Employer

Name of Dental Insurance (if applicable)

Occupation

If insurance coverage is through your spouse, spouses name

Spouses date of birth and SSN(if applicable for insurance needs)

Referred By

Have you received medical treatment during the past year Y/N

For what?

Have you had a skin reaction to jewelry? yes no

What medicines are you (your child) currently taking?

Women Are you pregnant? yes no

Taking birth control pills? yes no Nursing? yes no

Please circle any of the following that you have had, or now have...

- Heart Disease or Attack
- A.I.D.S./HIV P0S
- Diabetes
- Angina Pectoris
- Hepatitis A (Infectious)
- Emphysema
- High Blood Pressure
- Hepatitis B (Serum)
- Tuberculosis (TB)
- Heart Murmur
- Hepatitis C (non-A, non B)
- Asthma
- Rheumatic Fever
- Blood Transfusions
- Allergies or Hives
- Congenital Heart Lesions
- Drug Addictions
- Cortisone Medication
- Mitral Valve Prolapse
- Hemophilia (Bleeding Problems)
- Arthritis
- Heart Pacemaker
- Epilepsy or Seizures
- Glaucoma
- Heart Surgery
- Liver Disease
- Radiation Treatment
- Artificial Joints
- Psychiatric Treatment
- Pain in Jaw Joints
- Kidney Trouble
- Alcoholism
- Hay Fever
- Stroke
- Chemotherapy
- Sinus Trouble
- Anemia
- Thyroid Disease
- Ulcers
- Venereal Disease
- Other

Are you allergic to, or have you reacted adversely to any of the following?

- ☐ Aspirin
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Metals
- ☐ Latex
- ☐ Codeine
- ☐ Local Anesthesia
- ☐ Erythromycin
- ☐ Sedatives
- ☐ Any Other?

Please give the name and telephone number of the closest relative or friend (not living with you) to contact in case of emergency

Name _____ Phone _____

To the best of my knowledge, all answers are correct. I will notify Dr.Levey if any changes in my health or medication should occur. I consent to necessary treatment being performed on me by Dr. Levey and his staff, and also to the use of photos for educational and commercial purposes. Also, I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma; cardiac stimulation; temporary or rarely, permanent numbness; or muscle soreness. I understand that occasionally needles may break and require surgical retrieval.

Signature:_____ Date:_____

Dental History

What prompted you to seek dental care at this time?

Why did you leave your previous dentist?

Where shall we send for your x-rays? Please include: Name, Address and Phone of receiving office. Please leave blank if none.

How would you describe the condition of your teeth and gums?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
How long ago was your last thorough dental examination?	
Do you have regular dental check-ups?	○ yes ○ no How often?
Are you happy with the appearance of your teeth?	○ yes ○ no
Do you have any missing teeth?	○ yes ○ no
Are you aware of clenching or grinding your teeth?	○ yes ○ no
Do you usually have many cavities?	○ yes ○ no
Do you have any sensitivity in your teeth or gums?	○ yes ○ no
Do your gums feel tender, irritated, or swollen?	○ yes ○ no
How often do you use dental floss?	○ yes ○ no
Has any dental treatment been suggested that was not done?	○ yes ○ no
Do your gums bleed?	○ yes ○ no
Does food catch between your teeth?	○ yes ○ no
Do you avoid chewing or brushing in any part of your mouth?	○ yes ○ no
Have you lost or broken fillings?	○ yes ○ no
What concerns you most about dentistry?	○ yes ○ no
Do you have any concerns about your breath?	○ yes ○ no

How do you feel about dentistry in general? Circle one.

Great/ No problem/ Not great/ I don't like it ☐ ☐ ☐ ☐

If you could change anything about your teeth. what would it be?

It would be helpful if you would indicate below what things you are looking for most in choosing your dentist:

- ☐ Explains things so that I understand them
- ☐ Cares about me
- ☐ Is aware of my financial concerns
- ☐ Has a good appearance
- ☐ Has a pleasant staff
- ☐ Is gentle when working in my mouth
- ☐ Has an attractive office
- ☐ Keeps me and my family informed about office happenings and new trends in dentistry
- ☐ Is on time for my appointment
- ☐ Other

Signature:_____ Date:_____

Cosmetic Dental History (optional)

Hold a mirror 12-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully, then answer the following questions. If you are not happy with the appearance of your teeth, ask Dr. Levey how cosmetic dentistry can improve your smile.

1. Do you like the appearance of your teeth and your smile? ○ yes ○ no
   If not, explain
2. Are your teeth all in alignment (straight)? ○ yes ○ no
   If not, explain
3. Do you have spaces that you don't like? ○ yes ○ no

If yes, explain

4. Do you like the color of your teeth? ◯ yes ◯ no

If not, explain

5. Do you like the shape of your teeth? ◯ yes ◯ no

If not, explain

6. Are your teeth... ☐ chipped or ☐ protruding or ☐ hidden ???

7. Are your teeth wearing on the biting surfaces? ◯ yes ◯ no

If yes, explain

8. Are there old fillings or dental work you don't like looking at? ◯ yes ◯ no

If yes, explain

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

10. How would you like your teeth to look?