

Welcome

We are happy to have you join our great family of patients and friends. The benefits of a healthy, beautiful smile are immeasurable, and our goal is to help you obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so we can provide the best care possible for you. Thank You.

Name (first, MI, last) _____

How would you like to be addressed? _____

How did you hear about Dr. Calvo? _____

Address _____

City / State / Zip _____

Day Phone _____ Evening Phone _____ Emergency Phone _____

Mobile Phone _____ E-mail _____

Male ___ Female ___

Married ___ Single ___ Divorced ___ Widowed ___

Birthdate (MM/DD/YYYY) _____ Social Security Number: _____

About You	Your Spouse
Occupation _____ Employer _____ Address _____ _____ Phone _____	Name _____ Occupation _____ Employer _____ Address _____ _____ Phone _____
Insurance	
Insurance _____ Primary Insurance Company _____ Insurance Phone No. _____ Group No. _____ Employer _____	Insured's Name _____ Insured's ID No. _____ Insured's SSN. _____ Insured's Birthdate _____ Relationship to Patient _____

At Smile Studio LA **our focus is on appearance-related dentistry**. Our team also delivers routine general dental care as well. With flexible payment plans as well as phasing treatment over time, you and your family can achieve spectacular long-term results. Thank you so much for the opportunity to be of service

Your Health

Name _____

Have you been under the care of a medical doctor during the past two years? Y N

If Yes, what for? _____

Physician's name _____ Phone _____

Location/Address _____

Have you taken any medications or drugs during the past two years? Y N

if yes, please list any medication or drugs you have taken during the past two years Y N

Are you taking any medication or drugs currently?

including regular doses of aspirin, over-the-counter meds or herbal meds? Y N

If yes, please list the name and dosage _____

Are you aware of having any allergic or adverse reactions to any medications or substance? Y N

If yes, please list _____

Have you been a patient in the hospital during the past five years? Y N

Have you lost or gained more than 10 pounds in the past year? Y N

Do you take a bone-building drug such as Fosamax, Actonel, Zometa, or Pamidronate? Y N

If so, orally or IV? (circle one)

Do you currently use tobacco? Y N

If so, how long? _____ Do you want to quit? Y N

Indicate which of the following you have had or have at present:	
Heart (Surgery, Disease, Attack) Y N	Emphysema Y N
Congenital Heart Disease Y N	Tuberculosis Y N
High Blood Pressure Y N	Asthma Y N
Artificial Heart Valve Y N	Latex Sensitivity Y N
Heart Pacemaker Y N	Allergies/Sinus Trouble Y N
Arthritis/Rheumatism Y N	Radiation/Chemotherapy Y N
Cortisone Medicine Y N	Tumors Y N
Swollen Ankles Y N	Hepatitis A B C Y N
Stroke Y N	Venereal Disease / AIDS / HIV Y N
Diet (Special/Restricted) Y N	Cold Sores / Fever Blisters Y N
Artificial Joints (hip, knee, etc) Y N	Blood Transfusion Y N
Kidney Trouble Y N	Bruise Easily Y N
Diabetes Y N	Liver Disease / Yellow Jaundice Y N
Thyroid Problems Y N	Neurological Disorders Y N
Glaucoma Y N	Epilepsy or Seizures. Y N

Do you have or have had any disease, condition, or problem not listed? Y N

If yes, please list _____

Dental History

Name _____

Have you been under the care of a medical doctor during the past two years? Y N

If Yes, what for? _____

What prompted you to call our office for an appointment? _____

When was the last time you were seen by a dentist? _____

Did you have regular dental care as a child? Y N

As a child, did you have a lot, average, or very little tooth decay? _____

Do you have any dental anxieties? _____

Have you had or do you prefer Nitrous Oxide (laughing gas) during dental procedures? _____

Has a dental office ever helped you set up a treatment plan? _____

As you come into Smile Studio LA, what are your expectations, concerns, and or priorities? _____

If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do? _____

COSMETIC/ESTHETIC EVALUATION

Are you delighted with your smile? _____
 Please *rate* your smile from 1 to 10 (1= I hate my smile, 10= awesome) _____
 If you had a *magic wand* what, if anything would you change about your smile?

Do you have any *special* occasions coming up? _____

Through state of the art technology of Cosmetic Dentistry, we have the ability to help you achieve a World-Class Smile, *often overnight*.. Using Computer Assisted Dental Imaging and High Resolution Video Photography, we can simulate very closely how YOU would look after the improvements, PRIOR to any treatment! Imaging can be performed as part of your exam visit (at NO additional charge). Would you like to see what YOU would look like with a new and improved smile? Yes ___ No ___.

If yes, please check off all that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Lighten all front teeth showing | <input type="checkbox"/> Rebuild fractures(s) | <input type="checkbox"/> Straighten rotation | <input type="checkbox"/> Eliminate dark or stained fillings |
| <input type="checkbox"/> Lighten single tooth | <input type="checkbox"/> Lengthen | <input type="checkbox"/> Straighten angulation | <input type="checkbox"/> Reduce gum showing in smile |
| <input type="checkbox"/> Close spaces between teeth | <input type="checkbox"/> Shorten | <input type="checkbox"/> Eliminate crowding | <input type="checkbox"/> Repair uneven edges |

Please add anything you feel is important _____

Periodontal Screening

Have you ever had a bone loss evaluation? Y N
 Have you ever had pocket measurements? Y N
 Have you ever had Root Planing? Y N
 Do you suspect that you have mouth odor? Y N
 Have you ever been treated for periodontal disease? Y N
 Have you noticed any loosening or mobility of your teeth? Y N
 Do you suffer from pain and/or swelling of your gums, or have any pus around your gums? Y N

Problems of the Jaw

Have you ever been treated for TMJ? Y N
 Do you have more than one bite or have to clench to make your teeth fit together? Y N
 Do you wear or have you worn a bite appliance? Y N
 Are your teeth crowding or developing spaces? Y N
 Have you ever experienced:
 Clicking of the joints? Y N
 Pain? Y N
 Difficulty chewing? Y N
 Chewing what? _____
 Locking? Y N
 Chronic neck or shoulder pain? Y N
 Chronic headaches? Y N
 Morning headache? Y N
 Migraine headache? Y N

Habits ~ Do you...

Clench your teeth during the day? Y N
 Grind your teeth at night? Y N
 Bite your lips or cheeks regularly? Y N
 Sleep with your mouth open? Y N
 Chew tobacco or snuff? Y N
 Smoke cigarettes? Y N
 Hold foreign objects with your teeth (pencils, etc.)? Y N
 Have your teeth changed in the last five years? Y N
 Become shorter, Worn, or Thinner (circle one)

Please share with us any additions thoughts, comments, or concerns regarding your dental experiences or expectations:

Name _____ Date _____

Quality of sleep is very much related with oral health and overall wellness.
Please answer these few questions regarding your sleep patterns.

How likely are you to fall asleep in certain situations?
Please circle the answer that applies best to you

SITUATIONS	CHANCE OF FALLING ASLEEP			
	Would Never	Slight	Moderate	High Chance
a) Sitting and Reading	0	1	2	3
b) Watching TV	0	1	2	3
c) Sitting inactive in a public place (theater or meeting)	0	1	2	3
d) Riding as a passenger in a car for more than 1 hour	0	1	2	3
e) Lying down to rest in the afternoon when time permits	0	1	2	3
f) Sitting and talking to someone	0	1	2	3
g) Sitting quietly after lunch (without alcohol)	0	1	2	3
h) In a car, while stopped for a few minutes in traffic	0	1	2	3

SLEEP HABITS

Do you use more than two pillows to sleep? Y N
Do you have any trouble sleeping? Y N
Do you snore, or have you been told that you do? Y N
Do you awaken with jaw or head pain? Y N

WOMEN

Are you pregnant or think you may be pregnant? Y N
Are you nursing? Y N
Do you use birth control medication? Y N
Type: _____

I understand that to the best of my knowledge, the questions of this form have been accurately answered. I have documented my medical history and confirm it states past and present conditions. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any medical status or condition. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I authorize Smile Studio LA to perform all necessary dental procedures that I may need with my informed consent. I also give permission to Smile Studio LA to use any photos that may be taken used for lecturing, publishing, marketing, and educational purposes.

Patient/Guardian Signature _____ Date _____

Dr. Marilyn Calvo's Review

Doctors Signature _____ Date _____