FOREVER SMILE
General & Cosmetic Dentistry

5757 Wilshire Blvd, Ste. 350
Los Angeles, CA 90036
(323)634-9004

To better serve you, Please fill out this from completely. Our goal is to help you reach and maintain maximum oral health.

Last Name: _____

First Name: _____

Male ☐ Female ☐

Preferred Name:_____

DOB: _____ Age:_____ SS#_____

Address:_____

City: _____ State _____ Zip: _____

Email:_____

Single ☐ Divorced ☐ Separated ☐

Married ☐ Widowed ☐ Partner ☐

Home # _____ Cell #_____

Work #_____ Ext: _____

How Did you Find Us? _____

Reason For Your Visit:_____

Emergency Contact

Name: _____

Phone Number: _____

Dental Insurance

Insurance Name:_____

ID # _____ Group # _____

Employer:_____ Occupation: _____

Dental History

Last Dental Visit:_____ Last Exam & X-ray:_____

How Often Do you: Brush_____ Floss _____

Do your gums bleed when flossing? Yes or No

Do you notice a bad mouth odor or taste? Yes or No

Does food get caught between your teeth? Yes or NO

Do you have pain or sensitivity to:	YES	NO
Sweets?	☐	☐
Hot or Cold?	☐	☐
Biting or Chewing?	☐	☐

Have you had any of the Following:		
Orthodontic Treatment?	☐	☐
Oral Surgery?	☐	☐
Periodontal Treatment?	☐	☐
Serious Head or Mouth Injury?	☐	☐
Do you clench or grind?	☐	☐
Does your jaw click/pop?	☐	☐
Difficulty Chewing?	☐	☐
Difficulty Opening/Closing Jaw?	☐	☐
Pain around the ear, jaw or face?	☐	☐
Any Headaches, neck, or shoulder pain?	☐	☐
Do you have a night guard?	☐	☐

Medical History

Physician Name:_____ Phone #: _____

Date of Last Visit:_____ Last Blood Pressure: _____

Are you currently under their care? Yes or No

Explain: _____

	YES	NO
Are you taking any over-the-counter, prescription or herbal supplement drugs?	☐	☐
If yes, please list:_____		
Have you taken Fosamax or any other bisphosphonate for bone loss?	☐	☐
Have you ever taken any medication for weight loss? (Such as Fen-Fen, Pondimen, or Redux)	☐	☐
Are you taking any recreational drugs/marijuana?	☐	☐
Do you smoke?	☐	☐
If yes, are you interested in quitting?	☐	☐

Mark *Yes* or *No* if you've had any of the following:

	YES	NO
High Blood Pressure	☐	☐
Diabetes	☐	☐
Heart Attack	☐	☐
Pacemaker	☐	☐
Bruise easily	☐	☐
Stroke	☐	☐
Cancer/Chemo.	☐	☐
Radiation Treatment	☐	☐
Difficulty Breathing	☐	☐
Asthma	☐	☐
Sinus Problems	☐	☐
Tuberculosis (TB)	☐	☐
Dry Mouth	☐	☐
Hepatitis B/C	☐	☐
HIV/AIDS	☐	☐

	YES	NO
Hospitalizations	☐	☐
Kidney Problems	☐	☐
Stomach Ulcers	☐	☐
Liver Disease	☐	☐
Osteoporosis/Osteopenia	☐	☐
Psychiatric Treatment	☐	☐
Rheumatic/Scarlet fever	☐	☐
Seizures	☐	☐

Are you allergic to any of the following:

Aspirin	☐	☐
Anesthetic/Epinephrine	☐	☐
Penicillin	☐	☐
Codeine	☐	☐
Latex	☐	☐
Sulfa	☐	☐

Women Only:	YES	NO
Are you on birth control pills?	☐	☐
Are you undergoing hormone therapy?	☐	☐
Are you or think you are pregnant?	☐	☐
If Yes: # of weeks: _____		
Are you nursing?	☐	☐

Is there any medical condition not listed above that you would like to discuss with doctor? Please Explain.

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 health. It is my responsibility to inform Forever Smile and/or Dr. Mehrshad Shelyan of any changes in my medical status.

Patient Signature: _____ Date: _____

Doctor Signature: _____ Date: _____