SHAWN KELLER
SMILES BY DESIGN
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Please Help Us Understand You!

Patient Name: _____ Date: _____

Our office is different in that we give our patients our full attention.
We schedule one patient at a time, find out what is important to you and deliver what we promise.
Please answer the following questions so we can better understand your needs.

How can we help you?

_____

_____

_____

Are you looking for a new dental home? ❑ yes ❑ no

Do you plan on returning to your old dentist after your treatment is complete? ❑ yes ❑ no

I am interested in:

- ❑ Same Day New Smile™ (All-on-four)
- ❑ Stem Cell Therapy
- ❑ Golden Ratio Rejuvenation™ (Non-surgical Facelift)
- ❑ Smile Makeover
- ❑ TMJD Treatment
- ❑ Filling upgrade
- ❑ Metal-free Implants
- ❑ Sedation Dentistry

What is your time frame for the above? _____

Your first visit is designed to answer your questions and allow us to see if we are the right dentist for you. If you feel we are not the best fit, we will be happy to refer you to someone we know is a better match. If you feel we can help you, we will take records, do a thorough examination and give you specific options for your dental treatment.

Please begin thinking about the following: How important are the following concepts?

DENTAL HEALTH, PREVENTION, DENTAL COSMETICS, and FACIAL COSMETICS?

We will be discussing this with you shortly. Thank you!

Shawn Keller, DDS,
and the Team at Smiles by Design

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Your Health History

Patient Name _____ Date Of Birth _____

Address w/Zip_____

Home Phone # _____ Cell Phone # _____

Email _____ Who May We Thank For Referring You To Us _____

Employer_____Work Phone _____

Primary Physician's Name_____ _____ Physician Phone # _____

Date of Last Physical _____ Emergency Contact_____

Relationship to Emergency Contact _____Contact Phone #_____

Please answer Yes or No to the following:

AIDS/HIV	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tuberculosis	❑Yes	❑No
ANEMIA	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tumor or growth on Head/Neck	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Ulcer	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Headaches	❑Yes	❑No
Asthma	❑Yes	❑No	Liver Disease	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Bleeding abnormally, with extractions or surgery	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Blood Disease	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Limited Opening	❑Yes	❑No
Cancer	❑Yes	❑No	Pacemaker	❑Yes	❑No	Congested Ears	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Dizziness	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Posture Problems	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Clenching	❑Yes	❑No
Diabetes	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Grinding	❑Yes	❑No
Epilepsy	❑Yes	❑No	Stroke	❑Yes	❑No	Facial Pain	❑Yes	❑No
Fainting or dizziness	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No	Neck Ache	❑Yes	❑No
Glaucoma	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No	Bell's palsy	❑Yes	❑No
Heart Lesions	❑Yes	❑No	Thyroid Problems	❑Yes	❑No			
			Tonsillitis	❑Yes	❑No			

List any medications you are currently taking: Please include any blood thinning medications or aspirin?

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

_____yes _____no List Medication _____

_____

Circle if you have seen: an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery

Circle if you have seen any of the following healthcare professionals:

ENT, Neurologist, Chiropractor, or Massage Therapist

Do you snore, use a CPAP or have had a sleep study?

_____yes _____no

Have you ever had radiation to the head and/or neck?

_____ yes _____ no

Do you use tobacco products? _____yes _____no

Signature: _____ Date: _____