Ilona C. Casellini, D.M.D.
Swiss Quality Smile
WESTWOOD MEDICAL PLAZA
10921 Wilshire Blvd., Suite 1013
Los Angeles, CA 90024

Tel. 310-208-3125

Date: _____

Name: _____ , _____ _____
Last **First** **Middle**

Date of Birth: _____ **Age:** _____

Social Security Number: _____

Residence Address:

_____
Street

_____
City **State or Country** **Zip Code**

Local Address: (If different from Residence Address)

_____
Street **City** **Zip Code**

Home Phone Number: _____

Cellular Phone Number: _____

E-mail Address: _____

Occupation: _____

Place of Work or School:

_____

Emergency Contact: _____ _____
Name **Phone Number**

Name of Physician: _____ _____
Name **City**

Approximate Date of last Visit: _____

Name of Dentist: _____ _____
Name **City**

Approximate Date of last Visit: _____

Date of last Teeth Cleaning: _____

Referred by: _____

Found Office Via:

Newspaper _____ **Website** _____ **TV** _____ **Magazine** _____ **Radio** _____ **Other** _____

Health History

Circle yes or no (Leave blank if you do not understand)

Yes No Is your general health good?
Yes No Do you feel well today?
Yes No Are you currently being treated by a physician? If yes, for what?
_____
Yes No Are you currently taking any kind of medication? If yes, what are you taking?
_____
_____
Yes No Do you have heart valve problems or an artificial heart valve?
Yes No Have you had joint replacement surgery, such as a hip replacement?
If YES, when _____
Yes No Has a Dr. suggested that you take antibiotics before dental treatment?
Yes No Any major surgery? _____
Yes No Are you allergic to anything? If yes, to what? _____
Yes No Are you experiencing any kind of pain today?
Yes No Are you currently being treated by a dentist? If yes, for what?
_____
Yes No Have you had any unusual reactions prior to dental treatment?
Yes No Are you having any trouble breathing through your nose today?
Yes No Have you or do you smoke or use tobacco?
If yes, how much per day/how many years? _____

Do you currently have, or have had:

Yes No Heart disease
Yes No Congenital heart disease, heart murmur, mitral valve prolapse
Yes No Abnormal Blood Pressure
Yes No Breathing problems such as Asthma/COPD/Bronchitis
Yes No Bleeding problems (hemophilia) or bruising easily
Yes No Seizures or convulsions/epilepsy
Yes No Tuberculosis
Yes No Rheumatic Fever
Yes No Kidney Disease
Yes No Thyroid Problems
Yes No Diabetes
Yes No Cancer _____
Yes No HIV/AIDS
Yes No Immune Suppression Disorder
Yes No Radiation/ Chemo therapy
Yes No Hepatitis Type _____
Yes No Fainting spells or Nausea
Yes No Glaucoma or any eye problems
Yes No Ulcers
Yes No Acid Reflux
Yes No Vomiting episodes or any stomach related issues
Yes No Anxiety problems

Yes No Trouble opening or closing your mouth
Yes No Sores in your mouth or on your lips
Yes No Herpes
Yes No Sexually transmitted disease
Yes No Psychiatric/Psychological Care
Yes No Alcohol Addiction
Yes No Drug Addiction, if so, to what/how long _____

Are you sensitive to or have reactions to:

Yes No local anesthetic
Yes No sulfa drugs/sulfates/sulfides
Yes No antibiotics
Yes No pain medications such as Tylenol or Advil
Yes No codeine
Yes No latex rubber as found in gloves health professionals wear
Yes No sunlight or other light sources
Yes No metals or plastics
Yes No hydrogen peroxide

Women
Yes No Are you or might you be pregnant?
Yes No Are you currently taking Birth Control?

Dental Health Questions

Yes No I clench or grid my teeth during the day or at night
Yes No My gums bleed when I brush or floss
Yes No My gums feel tender or swollen
Yes No I have teeth that are sensitive to hot or cold
Yes No I have problems eating
Yes No I want my teeth whiter
Yes No I want my teeth straighter
Yes No I have had a facial injury or jaw injury
Yes No I have had orthodontics
Yes No I have concerns about bad breath
Yes No I snore, stop breathing or gasp for air during my sleep

How often do you brush? _____
How often do you floss? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. 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 will notify the doctor of change in my health or medication.

Patient Signature **Date** **Dentist Signature** **Date**