



**SMILE DESIGN STUDIO**  
for the health...for the beauty...of your smile

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### Contact Information

Mr\_\_ Mrs\_\_ Ms\_\_ Dr\_\_ First name\_\_\_\_\_ M. I.\_\_\_\_ Last name\_\_\_\_\_

Male\_\_ Female\_\_ Name preference\_\_\_\_\_ Birthdate\_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_

Driver's license #\_\_\_\_\_ Single\_\_ Married\_\_ Divorced\_\_ Widowed\_\_

Home street\_\_\_\_\_ City\_\_\_\_\_ State\_\_\_\_ Zip\_\_\_\_\_

Home phone #(\_\_\_\_)\_\_\_\_\_ Cell #(\_\_\_\_)\_\_\_\_\_ Work #(\_\_\_\_)\_\_\_\_\_ Ext\_\_\_\_\_

E-mail address\_\_\_\_\_ Referred by\_\_\_\_\_

Physician's name\_\_\_\_\_ Physician's phone #(\_\_\_\_)\_\_\_\_\_

Name of spouse or nearest relative\_\_\_\_\_ Contact phone#(\_\_\_\_)\_\_\_\_\_

### Dental History

Please list any concerns about the health of your mouth\_\_\_\_\_

\_\_\_\_\_

Please list any concerns that have affected your smile\_\_\_\_\_

\_\_\_\_\_

Has fear ever been an issue in a dental office? Explain\_\_\_\_\_

\_\_\_\_\_

Has any experience with a dental office been unpleasant? Explain\_\_\_\_\_

\_\_\_\_\_

Has the cost of dental treatment been a concern? Explain\_\_\_\_\_

\_\_\_\_\_

Are you experiencing any of the following?

Jaw pain	Y__ N__	Frequent headaches	Y__ N__	Grinding of teeth	Y__ N__
Tooth pain	Y__ N__	Red, swollen, or bleeding gums	Y__ N__	Food impaction	Y__ N__
Gum pain	Y__ N__	Blisters or mouth sores	Y__ N__	Floss breaking	Y__ N__
Clicking /popping jaw	Y__ N__	Sensitive teeth	Y__ N__	Teeth erosion	Y__ N__
Locking jaw	Y__ N__	Bad breath	Y__ N__	Yellowing teeth	Y__ N__
Ringing in the ears	Y__ N__	Loose or shifting teeth	Y__ N__	Fractured teeth	Y__ N__
Clenching of teeth	Y__ N__	Snoring	Y__ N__	Soft teeth	Y__ N__

## Dental History cont.

Have you had any of the following performed in your mouth?

Teeth whitening	Y__ N__	Braces	Y__ N__
Root canals	Y__ N__	Periodontal care	Y__ N__
Crowns	Y__ N__	Teeth extractions	Y__ N__
Erosion prevention	Y__ N__	TMJ treatment	Y__ N__

Premedication required prior to dental treatment? Y\_\_ N\_\_ Don't know\_\_

Name of present or previous dentist \_\_\_\_\_ Phone #(\_\_\_\_) \_\_\_\_\_

## Health History

Do you have or have you had any of the following medical conditions or diseases?

Asthma	Y__ N__	Heart disease	Y__ N__	Anemia	Y__ N__
COPD	Y__ N__	High blood pressure	Y__ N__	Leukemia	Y__ N__
Emphysema	Y__ N__	Heart murmur	Y__ N__	Bleeding disorder	Y__ N__
Tuberculosis	Y__ N__	Mitral valve prolapse	Y__ N__	HIV/AIDS	Y__ N__
Sinus problems	Y__ N__	Artificial valves	Y__ N__	Sexually transmitted disease	Y__ N__
Nasal congestion	Y__ N__	Heart bypass	Y__ N__	Herpes	Y__ N__
Tonsil/Adenoid removal	Y__ N__	Stroke	Y__ N__	Chronic yeast infections	Y__ N__
Ear congestion	Y__ N__	Pacemaker	Y__ N__	Fungal infections	Y__ N__

Diabetes	Y__ N__	Ulcers	Y__ N__	Shingles	Y__ N__
Hypoglycemia	Y__ N__	Gastrointestinal disorders	Y__ N__	Trigeminal neuralgia	Y__ N__
Vertigo/Dizziness	Y__ N__	Crohn's disease	Y__ N__	Bell's palsy	Y__ N__
Seizures	Y__ N__	Eating disorders	Y__ N__	Benign cancer	Y__ N__
Kidney disorders	Y__ N__	Osteoporosis	Y__ N__	Tumors	Y__ N__
Liver disorders	Y__ N__	Bone fractures	Y__ N__	Cancer in remission	Y__ N__
Hepatitis	Y__ N__	Arthritis	Y__ N__	Radiation therapy	Y__ N__
Thyroid disorders	Y__ N__	Head/Back injuries	Y__ N__	Chemotherapy	Y__ N__
Lupus	Y__ N__	Glaucoma	Y__ N__	Neurological disorders	Y__ N__
Fibromyalgia	Y__ N__	Tingling in fingers	Y__ N__	Psychiatric disorders	Y__ N__

Are you having or have you had any of the following?

Drug abuse or treatment	Y__ N__	Sudden weight loss	Y__ N__	Smoking 10 cigarettes	
Alcohol abuse or treatment	Y__ N__	Sudden weight gain	Y__ N__	or more per day	Y__ N__

Are you or have you been allergic to any of the following?

Penicillin	Y__ N__	Tetracycline	Y__ N__	Erythromycin	Y__ N__
Sulfa medications	Y__ N__	Aspirin	Y__ N__	Dental anesthetics	Y__ N__
Codeine	Y__ N__	Ibuprofen	Y__ N__	Valium	Y__ N__
Laughing gas	Y__ N__	Latex	Y__ N__	Other	Y__ N__

Please list all medications and dosages presently being taken or have taken in the last twelve months \_\_\_\_\_

Please list all herbals and vitamins presently being taken \_\_\_\_\_

Is there any other condition not mentioned above that we need to know about in order to accommodate you? \_\_\_\_\_

Are you a contact lens wearer? Y\_\_ N\_\_ Planning or had received facial cosmetic surgery? Y\_\_ N\_\_

Women:

Are you pregnant? Y\_\_ N\_\_ Nursing? Y\_\_ N\_\_ Planning a pregnancy? Y\_\_ N\_\_ Taking birth control? Y\_\_ N\_\_

## Authorization

I understand that the above information is necessary to provide me with the appropriate dental care. I have answered all responses correctly and to the best of my knowledge. I will inform this office of any changes in my medical condition or prescription drug administration before any treatment is rendered. I authorize this office to obtain releases from my respective health care providers for more detailed information.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the dentist and staff to perform all qualified services for diagnosis, treatment and relaxation. I give my consent to use local anesthetics and/or anxiety-free relaxants for completing dental treatment.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please download a copy of the above form and/or print a copy. Fill out the form completely and sign the authorization. The form can be brought in with you for your examination appointment or mailed in advance of your appointment to our address below.

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Lake Mary, FL. 32746

You can call us at 407-804-0770 to learn how you can fax or e-mail this form to us as well. Our e-mail address is [info@smilesbydrfalco.com](mailto:info@smilesbydrfalco.com).