

Mooney Family & Cosmetic Dentistry, PLLC
23535 IH-10 West, Suite 2202
San Antonio, TX 78257

Patient Medical History

Patient Name: _____ D.O.B _____

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Asthma | Due Date: _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Penicillin Allergy |
- OTHER: _____

List of medications: _____

● Have you ever had any complications following dental treatment? Yes No

If yes, please explain: _____

● Have you been admitted to a hospital or needed emergency care during the past two years? Yes No

No

If yes, please explain: _____

● Are you now under the care of a physician? Yes No

If yes, please explain: _____

● Name of Physician: _____ Phone: _____

● Do you have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date

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Smile Assessment Form

Please consider each statement carefully and circle YES or NO. Dr. Mooney and members of the dental team will discuss your responses with you in confidence.

1. I am concerned about the appearance of my teeth or smile.
YES NO
2. In social situations, I am embarrassed by my teeth or my smile
YES NO
3. There are some things about my upper front teeth that I would like to change.
YES NO
4. There are some things about my lower front teeth that I would like to change.
YES NO
5. I would like to know more about implant dentistry.
YES NO
6. I am interested in learning more about cosmetic dentistry.
YES NO
7. My smile is very important in my job as I deal with the general public.
YES NO

If I could change one thing about my smile I would _____

Please use the space below to indicate any other problems, concerns, or questions. We will make every effort to listen attentively to your concerns so that we can present you with the best possible treatment options. Thank you.