





*Cupertino Dental and Facial Esthetics*  
 10413 Torre Avenue Ste., 600  
 Cupertino, CA 95014  
 408.865.1777  
 www.smilegallery.com

8. List Any Allergies You May Have (Include soaps, cleansers, nuts, cinnamon, lavender, latex etc.) \_\_\_\_\_

9. Have You Been Told To Pre-Medicate For Dental Procedures, If So Why?  
 \_\_\_\_\_

10. Do You Have Or Have You Ever Had Any Of The Following Conditions?

\_\_Abnormal Heart Conditions \_\_Heart Murmurs \_\_High Blood Pressure \_\_Hepatitis \_\_Bell's Palsy/Facial Paralysis \_\_Mitral Valve Prolapse \_\_Low Blood Pressure \_\_High Blood Pressure  
 \_\_Lidocaine Allergy \_\_Latex Allergy \_\_Kidney Problems \_\_Thyroid Disease\_\_Prolonged Bleeding Time \_\_Circulatory Problems \_\_Fainting Spells \_\_Cold Sores \_\_Liver Problems  
 \_\_Rheumatic Fever \_\_Asthma \_\_Other (please describe below)

If yes with any, please describe \_\_\_\_\_

**Please mark all services that are of interest to you now or in the future:**

- General Dentistry                      Botox®                                      Zoom® Teeth Whitening
- Cosmetic Dentistry                      Fillers    Routine Care (cleaning and exam)
- Porcelain Veneers                      Facial Fat Reduction                      Dental Implants
- Gum Correction                              Oral Maxillofacial Surgery                      Skincare
- HydraFacialMD®                      TMJ Correction                      Invisalign                      Tooth Extractions

<b>Are you interested in dermal fillers or Botox® treatments to treat:</b>	<b>Yes</b>	<b>No</b>
Gummy smile	<input type="checkbox"/>	<input type="checkbox"/>
TMJ	<input type="checkbox"/>	<input type="checkbox"/>
Hyperhidrosis (excessive sweating of underarms, hands, feet)	<input type="checkbox"/>	<input type="checkbox"/>
Fine lines and wrinkles (crows feet, frown lines)	<input type="checkbox"/>	<input type="checkbox"/>
Lip enhancement	<input type="checkbox"/>	<input type="checkbox"/>
Fillers in the cheeks for collagen deficit	<input type="checkbox"/>	<input type="checkbox"/>
Contouring the cheeks	<input type="checkbox"/>	<input type="checkbox"/>

Are there any other dental or facial aesthetic treatments that you would like us to know about?

Yes   No

If yes, please describe \_\_\_\_\_



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**Dental History (If applicable)**

How often do you brush your teeth? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Do you have any current dental problems?  Yes  No

If yes, please describe: \_\_\_\_\_

<b>Are any of your teeth sensitive to:</b>	<b>YES</b>	<b>NO</b>
Hot or cold?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>
Biting or chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed a bad taste or bad breath?	<input type="checkbox"/>	<input type="checkbox"/>
Do you get cold sores, blisters, oral lesions?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed or hurt?	<input type="checkbox"/>	<input type="checkbox"/>
Anyone in your family have gum disease?	<input type="checkbox"/>	<input type="checkbox"/>
Any loose teeth or a change in your bite?	<input type="checkbox"/>	<input type="checkbox"/>
Does food get stuck in your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Do you:</b>	<input type="checkbox"/>	<input type="checkbox"/>
Clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Bite your lips or cheek?	<input type="checkbox"/>	<input type="checkbox"/>
Hold objects with your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Mouth breathe while awake/sleep?	<input type="checkbox"/>	<input type="checkbox"/>
Have tired jaws?	<input type="checkbox"/>	<input type="checkbox"/>
Smoke/chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
Use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>

<b>Have you ever had:</b>	<b>Yes</b>	<b>No</b>
Orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Bite adjusted?	<input type="checkbox"/>	<input type="checkbox"/>
Bite plate or mouth guard?	<input type="checkbox"/>	<input type="checkbox"/>
Serious injury to mouth or head?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Have you experienced?</b>		
Clicking or popping of the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Pain? (joiing, ear, side or face)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty opening or closing mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty chewing?	<input type="checkbox"/>	<input type="checkbox"/>
Headaches, neckaches	<input type="checkbox"/>	<input type="checkbox"/>
Sore muscles?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Are you happy with your smile?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Would you like straighter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Whiter teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want to keep all your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel nervous about dental Treatment?	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the information I have given above is true and accurate to the best of my knowledge.

I know of no medical conditions that I have not disclosed to the medical staff of Cupertino Dental and Facial Esthetics

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Physician/ Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_