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 Smile Enhancement Dentistry  
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**HEALTH HISTORY AND PERSONAL SMILE ENHANCEMENT FORM**

Welcome to Dr Silverman's office and a new cosmetic dental experience. Please take a few minutes to complete this confidential questionnaire and bring it with you at your consultation appointment. During your visit we will show you how you may be able to have the smile of your dreams, without shots or drilling and in only one visit. We are looking forward to seeing you soon.

Name \_\_\_\_\_ Birth Date: Mo/Day/Yr \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employed By \_\_\_\_\_  
 Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us \_\_\_\_\_  
 E-Mail \_\_\_\_\_ Please print legibly. Thank you.

Who will pay this account? Self \_\_\_ Spouse \_\_\_ Parent or Guardian \_\_\_  
 Responsible party's name \_\_\_\_\_ Relationship to you \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 In case of emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Are you now experiencing or have ever had any of the following:

Heart Disease	Y ___ N ___	High Blood Pressure	Y ___ N ___	Nervous Problems	Y ___ N ___
Radiation Treatment	Y ___ N ___	Liver Disease	Y ___ N ___	Kidney Disease	Y ___ N ___
Rheumatic Fever	Y ___ N ___	Asthma	Y ___ N ___	Heart Murmur	Y ___ N ___
Bleeding Gums	Y ___ N ___	Diabetes	Y ___ N ___	VD	Y ___ N ___
AIDS/HIV positive	Y ___ N ___	Hepatitis	Y ___ N ___	Epilepsy	Y ___ N ___
Sinus Problems	Y ___ N ___	Pregnant/Nursing	Y ___ N ___	Periodontal Disease	Y ___ N ___

Allergies: penicillin Y \_\_\_ N \_\_\_  
 latex Y \_\_\_ N \_\_\_  
 antibiotics Y \_\_\_ N \_\_\_  
 other allergies Y \_\_\_ N \_\_\_ Please List \_\_\_\_\_

Are you in good health Y \_\_\_ N \_\_\_ If no, explain \_\_\_\_\_

Please list any medications you are currently taking \_\_\_\_\_

Does any medication you take restrict you from sun exposure Y \_\_\_ N \_\_\_ if so, which \_\_\_\_\_

Are you having any discomfort now Y \_\_\_ N \_\_\_ if yes, explain \_\_\_\_\_

Do you bleed excessively when cut Y \_\_\_ N \_\_\_

When was your last dental check-up 6 mos \_\_\_ 12 mos \_\_\_ 24+mos \_\_\_

The date of your last cleaning \_\_\_\_\_ last x-rays \_\_\_\_\_

Do you smoke Y \_\_\_ N \_\_\_ if yes, how many cigarettes/ day 1 \_\_\_ 2-3 \_\_\_ 4+ \_\_\_

Do you drink coffee, tea, red wine or dark colas Y \_\_\_ N \_\_\_ if yes, how much 1 \_\_\_ 2-3 \_\_\_ 4+ \_\_\_

Do you want a brighter smile for a special occasion Y \_\_\_ N \_\_\_ if yes, please describe \_\_\_\_\_

