Dental Wellness and Health
Leila Chahine, D.M.D

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# NEW PATIENT PROFILE

Today's Date_____

Last Name_____ First Name_____ Date of Birth_____

Age_____ Male☐ Female☐ Marital Status_____ Social Security #_____

Home Address_____ City/State/Zip Code_____

Home Telephone #_____Cell Phone #_____

In case of emergency, please contact_____ Telephone #_____

Whom may we thank for referring you to our practice?
Name_____Other_____

# INSURANCE PROFILE

Insurance Company_____ Employer_____
Group#_____ Subscriber's Name_____
Date of Birth_____ Social Security or ID #_____Relationship to you: _____

**Secondary Insurance**

Insurance Company_____ Employer_____
Group#_____ Subscriber's Name_____
Date of Birth_____ Social Security # or ID#_____Relationship to you: _____

**For college students**: Name of college_____ City/State_____
Full Time Student☐ Part Time Student ☐ Expected year of graduation_____

# MEDICAL HISTORY PROFILE

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health issues or medications can impact your oral health. Thank you for answering the following questions:

Physician's Name & Address _____Date of last exam_____
Are you currently under the care of a physician for any medical condition?
_____
Have you ever been hospitalized, or had major surgery?
_____
Please list any prescription medication you are taking:
_____

Please list any over the counter medication or supplements you are taking:
_____
Have you ever been told that you need pre-medication for dental treatment? Yes☐ No☐



16 Hospital Avenue, Danbury, CT 06810

Are you allergic to any of the following: Antibiotic☐ Aspirin☐ Codeine☐ Acrylic☐ Metal ☐ Latex☐
Are you allergic to any medications?_____
Do you have any other allergies?_____
Have you ever had a negative reaction to local anesthetics (Novocain)? Yes☐ No☐

**Do you or have you ever had any of the following?**

| | | | |
|---|---|---|---|
| Heart Murmur/ Mitro-Valve Prolapse | Yes☐ No☐ | Liver or Kidney Disease | Yes☐ No☐ |
| Epilepsy or Seizures | Yes☐ No☐ | Injury to face of jaw | Yes☐ No☐ |
| Cancer/Chemotherapy | Yes☐ No☐ | Cold Sores/Fever Blisters/Herpes | Yes☐ No☐ |
| Blood Disorder | Yes☐ No☐ | Radiation Therapy | Yes☐ No☐ |
| Blood Transfusion | Yes☐ No☐ | Tuberculosis | Yes☐ No☐ |
| Excessive Bleeding/Bruise Easily | Yes☐ No☐ | Sinus Trouble | Yes☐ No☐ |
| Autoimmune Disease | Yes☐ No☐ | Asthma/Lung Disease | Yes☐ No☐ |
| Steroid Medication | Yes☐ No☐ | Lyme Disease | Yes☐ No☐ |
| Hepatitis A, B, C | Yes☐ No☐ | | |

Is there anything else about your medical history that we should know?
_____
_____
_____

What is your chief concern today? _____
Is there anything we need to know about your dental history?
_____
Former Dentist_____
Reason for leaving former dentist_____
When was your last cleaning & exam?_____
Have you had a full series of x-rays within the last 3 years? Yes☐ No ☐
How often do you brush your teeth? _____. Do you scrape your tongue Yes☐ No☐
How often do you floss your teeth ? _____ Do you use any mouth rinse? Yes☐ No☐
Are your teeth sensitive to: Heat☐ Cold☐ Sweets☐ Biting Pressure ☐ Other _____

I understand and authorize Drs. Henry Showah, Leila Chahine, herein after referred to as Dental Wellness & Health, PC to take all diagnostic materials necessary to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. I authorize Dental Wellness & Health, PC to perform and/or administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility.

This will also serve as The Acknowledgement of Receipt of Notice of Privacy Practice. I_____ have received a copy of this office's Notice of Privacy Practices.

Print Name_____ Signature _____ Date_____

The information provided above is accurate, and to the best of my knowledge:

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Doctor's Notes_____

_____

_____