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 #_____________________

Address/City/State/Zip ____

____

Email Address ____

Home Telephone #(______)______________Cell #(______)_______________Work #(______)______________

Please contact me at: Home ___ Work ___ Cell ___ Other______________________

Employer____ Occupation ______________________________

In case of emergency, please contact ____

Whom may we thank for referring you to our practice?

Name ____

Primary Insurance:

Insurance Company____ Group# ______________________

Employer _____________________________________ Subscriber's Name & Birthdate____________________

Subscriber's ID #____ Relationship to you____________________

Secondary Insurance:

Insurance Company____ Group# ______________________

Employer _____________________________________ Subscriber's Name & Birthdate____________________

Subscriber's ID #____ Relationship to you____________________

16 Hospital Avenue, Danbury, CT 06810

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?

If yes, please state condition: ____

Please list prior hospitalizations and surgeries: ____

____

Have you ever been told that you need pre-medication for dental treatment? Yes___ No___

If yes, state the name of the antibiotic: ____

Are you allergic to any of the following:

Local Anesthetics___ Acrylic _____ Metal_____ Latex ___

Aspirin _____ Penicillin____ Codeine____ Antibiotic_______

Other allergies? Yes___ No___

If yes, please list: ____

Have you ever had a negative reaction to local anesthetics (Novocain or Epinephrine)? Yes ____ No____

If yes, please explain: ____

Please list any prescription medication(s) & reason(s) you are taking:_____________________________________

____

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Please list any over the counter medication, supplements, or herbals you are taking: _________________________

____

MEDICAL HISTORY

Please circle all of the conditions which you have now and date anything you have had in the past:

Heart Murmur/Mitro-Valve Prolapse	Liver or Kidney Disease	Epilepsy or Seizures
Cancer/Chemotherapy	Cold Sores/Fever Blisters/Herpes	Blood Disorder
Radiation Therapy	Blood Transfusion	Excessive Bleeding/Bruise Easily
Sinus Trouble	Autoimmune Disease	Asthma/Lung Disease
Steroid medication	Lyme Disease	Hepatitis A,B,C
Injury to face or jaw	Tuberculosis	

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

____

____

DENTAL PROFILE

What is your chief concern today? ____

____

Is there anything we need to know about your dental history? ________________________________

____

Dentist____

Date of last dental visit? ____

Have you had your teeth cleaned regularly? Yes__ No___ How Often? _________

Have you had a complete dental examination, including x-rays, within the last three years? Yes___ No___

How many times do you: Floss/week? _____________ Brush/week? _____________

Do you scrape your tongue? Yes___ No___ Do you use any mouth rinse? Yes___ No___

Do you avoid brushing any areas of your mouth because of tenderness? Yes___ No___

How many times per day do you consume acidic beverages? (i.e. soft drinks, coffee, iced tea)______________________

____

Are your teeth sensitive to: Heat____ Cold____ Sweets____ Biting Pressure____ Other ___________________________

Please initial each paragraph:

________I understand and authorize Dr. Leila Chahine, herein after referred to as Dental Wellness & Health, PC to take all diagnostic materials necessary for diagnostic purposes. This may include radiographs, diagnostic models, and photographs. I understand that the dental treatment agreed upon is my financial responsibility.

________I hereby acknowledge that I was given the opportunity to review the Notice of Privacy Act (HIPPA).

________I give permission to Dr. Chahine & staff to discuss any medical & dental health related information including appointments and premedication protocol with: ________________________________.

________Dental Wellness & Health, P.C. may discuss payment issues with family members or other personal representatives, including the subscriber of the insurance plan, unless I request special privacy protections.

________Dental Wellness & Health, P.C. may share my dental information with other professionals if consultation is deemed beneficial.

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

Signature____

PrintName____

Date____

In case you are unable to sign digitally, please check the box below:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above information.

DOCTOR'S NOTE:____

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