Dental Wellness and Health
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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_____

For college students:

Name of College_____City/State_____FT/PT?_____

Anticipated date 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?

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: _____

Are you currently taking, or have you taken in the past 3 years, Bone density strengthening medication

(Bis-phosphonates)? Yes___ No___

If yes, please explain: _____

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

_____

_____

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

_____

Do you smoke? Yes___ No___ For how long?_____ How much per day? _____

Do you drink alcohol? Yes___ No___ For how long?_____ How much per day? _____

Women:

Are you pregnant? Yes___ No___ Are you currently nursing? Yes___ No___

Are you taking oral contraceptive (birth control pills)? Yes___ No___

If yes, name medication: _____

MEDICAL HISTORY

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

- AIDS
- Alcohol Addiction
- Alzheimer's Disease
- Anemia
- Angina
- Arthritis
- Artificial Joints
- Artificial/Leaky Heart Valve
- Asthma
- Blood Disease
- Blood Transfusion
- Bruise Easily
- Cancer
- Chemotherapy
- Cold Sores/Fever Blisters
- Contact Lenses
- Convulsions
- Cortisone Medication
- Diabetes
- Diet: (Special/Restricted)
- Dizziness
- Drug Addiction
- Emphysema
- Epilepsy
- Excessive Bleeding
- Excessive Thirst
- Fainting
- Frequent Cough
- Glaucoma
- Growths
- Hay Fever
- Headaches
- HIV Positive
- Head Injuries
- Heart (Attack, Disease, Surgery)
- Heart Murmur
- Hemophilia
- Hepatitis- A, B, C
- Herpes
- High Blood Pressure
- Hives or Rash
- Hypoglycemia
- Irregular heartbeat
- Jaundice
- Kidney Disease
- Latex Sensitivity
- Leukemia
- Liver Disease
- Mental Disorders
- Mitral Valve Prolapse
- Nervous Disorders
- Pacemaker
- Psychiatric Care
- Pregnancy
- Due Date: _____
- Radiation Treatment
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Sinus Problems
- Sleep Apnea
- Smoke/Chew Tobacco
- Stomach Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Tumors
- Ulcers
- Venereal Disease

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

_____

AESTHETIC PROFILE

Are you happy with the appearance of your smile? Yes___ No___

Would you like your teeth to look whiter? Yes___ No___

Are you concerned about existing dental amalgam (silver) fillings? Yes___ No___

If you could improve your smile, what would you like to see changed? _____

_____

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___

Have you had any previous injuries to the face or jaw? _____

_____

Have you ever been diagnosed with TMJ problems in the past? Yes___ No___

If yes, please explain: _____

_____

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)_____

_____

PLEASE CHECK ANY THAT OF THE FOLLOWING THAT PERTAIN TO YOU:

- ___ Bleeding Gums
- ___ Bad Breath
- ___ Food Traps
- ___ Loose Teeth
- ___ Sensitivity to Sweets
- ___ TMJ/ Jaw Problems
- ___ Sensitivity to Cold
- ___ Clench/Grind Teeth
- ___ Sensitivity to Hot
- ___ Snoring
- ___ Sensitivity to Biting
- ___ Sleep Apnea

HAVE YOU EVER HAD? PLEASE CHECK AND DATE:

- ___ Periodontal (Gum) Therapy
- ___ Bite Adjustment
- ___ Orthodontics/Braces
- ___ Extraction of Wisdom Teeth

WHAT WOULD PREVENT YOU FROM RECEIVING DENTAL TREATMENT?

- ___ Cost
- ___ Fear
- ___ Lack of Time
- ___ Lack of Importance

ARE YOU AT HIGH RISK FOR SLEEP APNEA?

This is the "Stop-Bang" Scoring Model. This will help to determine if you are risk for sleep apnea.

STOP

Do you **SNORE** loudly (loud enough to be heard through closed doors)?	Yes ☐	No ☐
Do you often feel **TIRED**, fatigued, or sleepy during daytime?	Yes ☐	No ☐
Has anyone **OBSERVED** you stop breathing during your sleep?	Yes ☐	No ☐
Do you have, or are you being treated for high blood **PRESSURE**?	Yes ☐	No ☐

BANG

BMI: more than 35kg/m2?	Yes ☐	No ☐
AGE: over 50 years old?	Yes ☐	No ☐
NECK: circumference > 16 inches (40cm)?	Yes ☐	No ☐
GENDER: male?	Yes ☐	No ☐

For every yes, please add one point. **Total Score:** 0

Low Risk of OSA:	0-2	☐
Intermediate Risk of OSA:	3-4	☐
High Risk of OSA:	5-8	☐

THE EPWORTH SLEEPINESS SCALE

Date: _____ Name: _____ D.O.B._____Age_____

This questionnaire measures your general level of daytime sleepiness. Be sure to review your responses with your healthcare professional. Regardless of the questionnaire results, if you have concerns, you are encouraged to discuss them with your healthcare professional.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

***-0-** Would **never** doze* ***-1- Slight** chance of dozing* ***-2- Moderate** chance of dozing* ***-3- High** chance of dozing*

Situation	**Chance of Dozing**
• Sitting and reading……	0
• Watching television……..	0
• Sitting inactive in a public place (e.g., a theater or a meeting)……..…..	0
• As a passenger in a car for an hour without a break…….	0
• Lying down to rest in the afternoon when circumstances permit…….	0
• Sitting and talking to someone…….	0
• Sitting quietly after a lunch without alcohol……	0
• In a car, while stopped for a few minutes in traffic……	0

Total Score: 0 ----------

Higher scores are associates with more daytime sleepiness. You should discuss your responses and your score with your healthcare professional. This questionnaire is not intended to make a diagnosis or take the place of talking with your healthcare professional.

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:_____

_____

_____