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____________

For college students: Name of
College___________________________City/State______________________FT/PT?________

Anticipated date of graduation_____________

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, state condition:

____

Please list prior hospitalizations and surgeries:

____

Are you currently taking, or have you taken in the past 3 years, Bone density strengthening medication (bis-phosphonates)? Yes / No

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

____

____

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

Have you ever been told that you need pre-medication for dental treatment? Yes_____ No_____

Are you allergic to any of the following: Antibiotic_____ Acrylic____ Metal _____ Latex____

Are you allergic to any medications? If yes, state medication:
____

____

Please list any known allergies:____

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

Do you smoke? No____ Yes____ For how long?_________ How much per day? ___________

Do you drink alcohol ? No_Yes__ 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 circle all of the conditions which you have now and date anything you have had in the past:

Heart Murmur/ Mitral Valve Prolapse	Stomach Problems/Ulcers	Hip/Joint Replacement
Liver or Kidney Disease	Reflux	Arthritis
Heart Disease	Gastrointestinal Problems	Lyme Disease
Angina	Diabetes	Autoimmune Disease
Pacemaker/Defibrillator	Glaucoma	Epilepsy or Seizures
High Blood Pressure	Hypoglycemia	Alcoholism/Drug Addiction
Low Blood Pressure	Cancer	Injury to the face or jaw
Stroke	Type:____________________	Psychiatric Disease
Sleep Apnea		Anxiety/Panic Attacks
Asthma	Radiation Therapy	Venereal Disease
	Chemotherapy	AIDS/HIV
Lung Disease/COPD	Thyroid Problems	Human Papilloma Virus (HPV)
Sinus Trouble	Blood Disorder	Cold Sores/Fever Blisters/Herpes
Blood Transfusion Date:__________________________	Hepatitis A, B, C	Excessive Bleeding/Bruise Easily
	Tuberculosis	

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____

When was your 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___

What form of sugar do you consume daily? _____________________

How many portions of fruits and vegetables do you consume daily? _________

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

How often do you brush? _______________Floss? _________________________

Do you scrape your tongue? Yes_____ No_____ Do you use any mouth rinse? Yes____ No____

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

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

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

HAVE YOU EVER HAD? PLEASE CHECK AND DATE:

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

WHAT WOULD PREVENT YOU FROM RECEIVING DENTAL TREATMENT?

___ Cost
___ Lack of Time
___ Fear
___ 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 at “high” or “low” risk for sleep apnea.

Do you snore loudly?

_______Yes _______No

Do you often feel tired, fatigued or somnolent during day?

_______Yes _______No

Has anyone observed your breathing to stop during sleep?

_______Yes _______No

Are you being treated for high blood pressure?

_______Yes _______No

Is you BMI more than 35 kg/m(2)?

_______Yes _______No

Is your age greater than 50 years?

_______Yes ________No

Is your neck circumference greater than 40cm?

________Yes ________No

Is your gender male?

________Yes ________No

____ ___________________________

Signature Date

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).

_______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____

DOCTOR'S NOTE:

____
____
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