

**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 \_\_\_\_\_

Full Time? \_\_\_\_ Part Time? \_\_\_\_ 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, 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 (bisphosphonates)? 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)? 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 check 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                   | Hepatitis A, B, C         | Excessive Bleeding/Bruise Easily |
| Date:_____                          | Tuberculosis              |                                  |

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

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**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?\_\_\_\_\_

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## **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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Bleeding Gums         | <input type="checkbox"/> Bad Breath         |
| <input type="checkbox"/> Food Traps            | <input type="checkbox"/> Loose Teeth        |
| <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> TMJ/ Jaw Problems  |
| <input type="checkbox"/> Sensitivity to Cold   | <input type="checkbox"/> Clench/Grind Teeth |
| <input type="checkbox"/> Sensitivity to Hot    | <input type="checkbox"/> Snoring            |
| <input type="checkbox"/> Sensitivity to Biting | <input type="checkbox"/> Sleep Apnea        |

### **HAVE YOU EVER HAD? PLEASE CHECK AND DATE:**

- |  |   |
|--|---|
| <input type="checkbox"/> Periodontal (Gum) Therapy | <input type="checkbox"/> Bite Adjustment            |
| <input type="checkbox"/> Orthodontics/Braces       | <input type="checkbox"/> Extraction of Wisdom Teeth |

### **WHAT WOULD PREVENT YOU FROM RECEIVING DENTAL TREATMENT?**

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> Cost         | <input type="checkbox"/> Fear               |
| <input type="checkbox"/> Lack of Time | <input type="checkbox"/> Lack of Importance |



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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