Dentistry for Health and Wellness

F. John Sayyah, M.D., D.D.S., P.L.L.C
16701 NE 80th Street, Suite 200 Redmond, WA 98052

NEW PATIENT INFORMATION

About You...

First Name (MI)
Last Name
❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. I prefer to be called
Birthdate SS#
Home Address
City State Zip
❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
Phone (H) Phone (M)
Phone (W) Ext.
Email
Employer
Employer's City & State
How long there Occupation
The best time to contact you?
Whom may we thank for referring you?

Other family members seen by us:

Spouse Information...

His / Her Name
Employer
Work # Ext.
Birthdate

Redmond Town Dental
F. John Sayyah, MD, DDS, PLLC
16701 NE 80th Street, Suite 200
Redmond, WA 98052
Phone (425) 556-9795
Fax (425) 556-9352
www.redmondtowndental.com
E-mail: contact@redmondtowndental.com

Dental Insurance

Primary Dental Insurance

Name of Insurance Co.
Address

Phone #
Group # Policy #
Insured's Name
Relation
Insured's Birthdate / / Insured's SS#
Insured's Employer

Secondary Dental Insurance

Name of Insurance Co.
Address

Phone #
Group # Policy #
Insured's Name
Relation
Insured's Birthdate / / Insured's SS#
Insured's Employer

Emergency Contact

In the event of an emergency the person to contact?
Name of Contact
Relationship
Home #
Work # Mobile #

Medical History Survey

Are you currently under the care of a physician? ☐ Yes ☐ No
Physician's name:______________________________
Physician's phone:______________________________
Are you currently taking any prescriptions/over the counter drugs?
Please List: ☐ Yes ☐ No

____
____
____

Your current physical health ☐ Excellent ☐ Fair ☐ Poor
Do you smoke and/or chew tobacco? ☐ Yes ☐ No
How much do you smoke and how long have you smoked for?
____
Please list any serious medical conditions or surgeries that you have ever had:
____
____

Have you had or have any of the following diseases or medical problems? Please note it is No and then Yes for this section.

No Yes
- ☐ ☐ Heart or Blood Pressure Problems
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Blood Disorders or Abnormal Bleeding
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Allergy and/or Sinus Problems
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Breathing and/or Lung Problems
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Intestinal and/or Acid Reflux Issues
  If yes, please explain__________
  ____
  ____

No Yes
- ☐ ☐ Liver Disease and/or Hepatitis
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Kidney or Renal Disease
  If yes, please explain__________
  ____
  ____
- ☐ ☐ Bone or Joint Problems
  - ☐ Arthritis
  - ☐ Back and/or neck pain
  - ☐ Joint replacement (e.g. pins, implants)
    If yes, date of surgery?______
- ☐ ☐ Immune Problems
  - ☐ HIV or AIDS
- ☐ ☐ Endocrine Problems
  - ☐ Thyroid problems
  - ☐ Diabetes Type I or Type II
  - ☐ Taking thyroid medication
- ☐ ☐ Frequent urination
- ☐ ☐ Excessive thirst or dry mouth

No Yes
- ☐ ☐ Neurological or Emotional Issues
  - ☐ Emotional problems
  - ☐ Nervous disorders
  - ☐ Fainting spells
  - ☐ Seizures or Epilepsy
  - ☐ Frequent Headaches
  - ☐ Migraines
  - ☐ Tremors or shaking
  - ☐ Taking antidepressants
- ☐ ☐ STDs or Venereal Disease
  - ☐ Herpes
- ☐ ☐ Cancer/Tumor
- ☐ ☐ Radiation and/or Chemotherapy
  If yes, please date?________
  Type?________________
- ☐ ☐ Vision Problems
- ☐ ☐ Glaucoma
- ☐ ☐ Wear contact lenses
- ☐ ☐ Hearing loss
- ☐ ☐ History of Alcohol Abuse
- ☐ ☐ Drug Abuse
  If yes type?____________

Yes No
- ☐ ☐ I have consumed alcohol within the last 24 hours.
- ☐ ☐ Do you need premedication or antibiotics prior to dental treatments?
- ☐ ☐ Do you take or have you ever taken Bisphosphonates (e.g. Fosamax, Boniva, etc.) for Osteoporosis or other conditions?

Are you allergic, or have you reacted adversely to the following?

Yes No
- ☐ ☐ Local anesthetics (e.g.Novocaine)
- ☐ ☐ Penicillin
- ☐ ☐ Sulfa drugs
- ☐ ☐ Sedatives, sleeping pills
- ☐ ☐ Aspirin
- ☐ ☐ Ibuprofen or other NSAIDs
- ☐ ☐ Codeine, Demerol or other narcotics
- ☐ ☐ Reaction to metals, including nickel
- ☐ ☐ Latex

Please list any other drugs that you are allergic to:
____

During the past year, have you taken any of the following?

Yes No
- ☐ ☐ Antibiotics
- ☐ ☐ Anticoagulants (e.g. Coumadin)
- ☐ ☐ High blood pressure medicine
- ☐ ☐ Insulin, or other diabetic medication
- ☐ ☐ Aspirin
- ☐ ☐ Nitroglycerin, Digitalis, B-blockers for heart trouble
- ☐ ☐ Cortisone (steroids)
- ☐ ☐ Natural remedies
- ☐ ☐ Nonprescripton drugs/supplements

Please list any other drugs:
____

FOR WOMEN: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes — Week#__________ ☐ No

Are you nursing? ☐ Yes ☐ No

Doctor Notes:
____
____

Dental History Survey

What is your reason for coming in today, if you have any pain or sensitivity concerns please explain? ____________________

How long has this been an issue? ____________ Are you currently in pain? ☐Yes ☐No

Have you had regular dental care (e.g. every 6 months)? ☐Yes ☐No If no then what intervals? ____________

How long ago was your last visit to the dentist? ________ Reason for the last visit: ____________

How long ago was your last dental cleaning? ____________ Do you desire complete & comprehensive oral care? ☐Yes ☐No

Previous/Present Dentist: ____________ Reason for changing dentist: ____________

Is there anything else about having dental treatment that you would like us to know? ☐Yes ☐No

If yes, please describe: ____________

Are you anxious being at the dentist? ☐Yes ☐No If yes rate: Least 1 2 3 4 5 6 7 8 9 10 Most

Are you interested in learning more about sedation dentistry: ☐Yes ☐No

Have you had any previous problems with dental treatment: ☐Yes ☐No

If yes please explain: ____________

Have you had or have any of the following dental conditions? (Please answers all the questions individually)

Yes	No	
☐	☐	Do you gag easily?
☐	☐	Do you have any problems with taking dental x-rays?
☐	☐	Do you wear dentures?
☐	☐	Does food catch between your teeth?
☐	☐	Do you have any difficulty chewing your food?
☐	☐	Do you chew on only one side of your mouth?
☐	☐	Do you avoid brushing your mouth because of pain?
☐	☐	Have you noticed any slow-healing sores in your mouth?
☐	☐	Do your gums bleed easily?
☐	☐	Do your gums bleed when you floss?
☐	☐	Do your gums feel tender or swollen?
☐	☐	Have you been diagnosed with gum or periodontal disease?
☐	☐	Has scaling and root planing ever been done for gum disease?
☐	☐	Have you ever had any type of gum surgery e.g. grafting?
☐	☐	Are you concerned about your recession of your gums?
☐	☐	Do you ever clinch or grind you teeth (awake or sleep)?
☐	☐	Do you have or ever had a night guard?
☐	☐	Have you ever been told you need a night guard?
☐	☐	Do you smoke? How cig/day______How many years_____
☐	☐	Do you chew tobacco?

Yes	No	
☐	☐	Are you satisfied with the appearance of your teeth or smile?
☐	☐	Do you have any staining of your teeth?
☐	☐	Are you interested in getting your teeth whiter?
☐	☐	Are you unhappy with any silver or discolored fillings?
☐	☐	Do you have any crowns that are unnatural or unattractive?
☐	☐	Do you feel that your breath is not as "fresh" as ideal?
☐	☐	Have you ever been told you have bad breath?
☐	☐	Do you feel more often than not that your mouth is dry?
☐	☐	Do you breethe through your mouth (awake or sleep)?
☐	☐	Have you ever had dental extractions?
☐	☐	Do you have one or more missing teeth?
☐	☐	Do you have any unattractive spaces between your teeth?
☐	☐	Will having a more attractive smile add to your confidence?
☐	☐	Are you interested in getting your teeth straighter?
☐	☐	Have you had orthodontic treatment (e.g. braces)?
☐	☐	Are your teeth sensitive to hot or cold foods/drinks?
☐	☐	Are your teeth sensitive to sweets?
☐	☐	Are your teeth sensitive when you chew or bite?
☐	☐	Do you have any root canaled or endodontically treated teeth?

How often do you brush your teeth: ☐Once a day ☐Twice a day ☐Other____________

Type of brush(es) do you use : ☐Manual Bristles (e.g. soft)________ ☐Electric Sonicare ☐Electric Other:____________

How often do you floss your teeth: ☐Once a day ☐Twice a week ☐Once a week ☐Rarely or never ☐Other:____________

Do you use any other cleaning aids or tools: ☐Yes ☐No ____________ Do you regularly brush your tongue? ☐Yes ☐No

Do you use a mouth wash (e.g. Listerine)? ☐Yes ☐No________ Do you feel meticulous about your oral hygiene? ☐Yes ☐No

Do you drink more than two bottles or cups of combined sodas, sport or energy drinks, coffee or tea with milk or sugar? ☐Yes ☐No

If yes, how much of each: ____________

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Doctor Notes:

Signature ____________

Date ____________

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TMJ AND OCCUSAL SCREENING

Name ______________________ Signature X ______________________ Date ________

Many people experience symptoms that they feel are "normal" or are caused by other things such as allergies and stress. Many of these symptoms can actually be related to a "bad bite". Please take a moment to look over the screening symptoms below. Please check the appropriate line if you are experiencing or have experienced any of these symptoms in the past. Please feel free to ask us any questions.

- ☐ Do you avoid eating certain foods because of pain?
- ☐ Does your jaw make noises when you chew or yawn?
- ☐ Has your jaw ever locked (open or closed)?
- ☐ Does your jaw ever feel tired?
- ☐ Do your have earaches or pain in front of your ears?
- ☐ Does your jaw ever feel sore specially upon awaking?
- ☐ Does jaw pain affect your sleep or other daily activities?
- ☐ Do you find jaw pain frustrating or depressing?
- ☐ Do you ever take medication because of jaw pain?
- ☐ Have you been diagnosed with TMD (temporomandibular jaw disorder)?
- ☐ Any chronic or more than usual facial or neck pain?
- ☐ Are you not able to open your mouth as far as you want?
- ☐ Are you aware of an uncomfortable bite?
- ☐ Have you ever had jaw trauma?
- ☐ Are you a habitual gum chewer or nail etc. biter?

Please give details about your symptoms if you wish:

____

____

____