



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.

<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart or Blood Pressure Problems If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Disorders or Abnormal Bleeding If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergy and/or Sinus Problems If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Breathing and/or Lung Problems If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Intestinal and/or Acid Reflux Issues If yes, please explain _____ _____</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Disease and/or Hepatitis If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney or Renal Disease If yes, please explain _____ _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone or Joint Problems <input type="checkbox"/> Arthritis <input type="checkbox"/> Back and/or neck pain <input type="checkbox"/> Joint replacement (e.g. pins, implants) If yes, date of surgery? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Immune Problems <input type="checkbox"/> HIV or AIDS</p> <p><input type="checkbox"/> <input type="checkbox"/> Endocrine Problems <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Diabetes Type I or Type II <input type="checkbox"/> Taking thyroid medication</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Excessive thirst or dry mouth</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological or Emotional Issues <input type="checkbox"/> Emotional problems <input type="checkbox"/> Nervous disorders <input type="checkbox"/> Fainting spells <input type="checkbox"/> Seizures or Epilepsy <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Tremors or shaking <input type="checkbox"/> Taking antidepressants</p> <p><input type="checkbox"/> <input type="checkbox"/> STDs or Venereal Disease <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer/Tumor <input type="checkbox"/> Radiation and/or Chemotherapy If yes, please date? _____ Type? _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Vision Problems <input type="checkbox"/> <input type="checkbox"/> Glaucoma <input type="checkbox"/> <input type="checkbox"/> Wear contact lenses</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> <input type="checkbox"/> History of Alcohol Abuse <input type="checkbox"/> <input type="checkbox"/> Drug Abuse If yes type? _____</p>
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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
 Nonprescription drugs/supplements

Please list any other drugs:

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

Are you pregnant? Yes — Week# _____ No

Are you nursing? Yes No

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 clench 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 breathe 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 you 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:
