



Dentistry for Health and Wellness

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NEW PATIENT INFORMATION

Patient Information

Patient Name: _____ Date: _____
Last First Middle Preferred Name
Gender: Male Female Birth Date: _____
Phone (H): _____ (Work): _____ Ext: _____ Best time to call: _____
Address: _____ Apt. Num: _____
City State Zip Code
Contact Email: _____

Responsible Party Information

Parent/Guardian Name: _____
Social Security #: _____ Birth Date: _____
Phone (H): _____ (Work): _____ Ext: _____ Best time to call: _____
Address, if different from above:
Street Apt. Num City State Zip Code
Employer Name: _____ Occupation: _____
Address: _____
Street Apt. Num City State Zip Code
Insurance Plan Name: _____
Address: _____
Street City State Zip Code
Phone: _____ Group #: _____

continued...

Medical History

Name of physician: _____ Phone/Address: _____

Date of last visit? _____ Reason? _____

Is your child currently under the care of a physician? Yes No Reason? _____

Describe your child's overall physical health: Excellent Good Fair Poor

Please list medication(s) currently taking: _____

Has your child ever been hospitalized or under a physician's care in the last two years? Yes No

If so, why? _____

For Females: Taking birth control pills? Yes No Pregnant? Yes No Due Date: _____

Has your child had any of the following? Please check those that apply:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Abnormal bleeding | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Learning Disabilities | <u>Allergy/Adverse Reaction to:</u> |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Aspirin |
| _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy-Seizures | <input type="checkbox"/> Mumps | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Hearing Trouble | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Nitrous Oxide (Laughing Gas) |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Nickel Allergy |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Novocain/Xylocaine |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Jaundice | _____ | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Joint Replacement | _____ | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Kidney Disease | | |

Are there any other conditions we should know about?

Dental History

Is this your child's first dental visit? Yes No

If No, Former Dentist _____ Address: _____ Phone: _____

Date of Last Dental Visit: _____ Date of last x-ray: _____

Reason for this visit? _____

Does your child brush daily? Yes No Floss? Yes No

Does an adult assist with brushing/flossing? Yes No

Does your child experience pain or discomfort in the jaw joint? Yes No

Has your child experienced a mouth or jaw injury? Yes No

Was your child bottle fed? Yes No If yes, how long? _____

Does your child have any speech problems? Yes No If yes, Are you seeing a speech therapist? Yes No

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes No

Is fluoride taken in any of the following forms? Water supply Vitamins Toothpaste Tablets Rinse/Gel

Other information about your child's dental health or previous treatment

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are any changes in my child's health status, I will inform the doctor at the next appointment without fail.

Signature of parent or guardian

Date: