

GUEST INFORMATION

1. Please enter your information

Last Name:	First Name:	Middle Initial:
Preferred Name:	Age:	Date of Birth:
Gender:	Marital Status:	# of Children:
☐ Female ☐ Male	☐ Single ☐ Married	
	☐ Domestic Partner ☐ Child	
Address:		
Home Phone:	Work Phone:	Mobile Phone:
Email:	Social Security:	
Employer:	Occupation:	
Are you a full time student?	If yes, name of School?	
☐ Yes ☐ No		

2. Emergency Contact Information

Emergency Contact Name:	Phone Number:

3. IF THE GUEST IS A MINOR, PLEASE FILL OUT THE BOX BELOW

Are you:	
☐ Parent ☐ Guardian	
Name:	Social Security:
Address:	

DENTAL INSURANCE

4. PRIMARY CARRIER

Insured's Name:	Birth date:	Relation:
_____	_____	_____
Employer:	Social Security:	
_____	_____	
Insurance Company:	Group Number:	
_____	_____	
Insurance Address:	Phone:	
_____	_____	
Annual Maximum:	Deductible:	Remaining Amount:
_____	_____	_____

5. SECONDARY CARRIER

Insured's Name:	Birth date:	Relation:
_____	_____	_____
Employer:	Social Security:	
_____	_____	
Insurance Company:	Group Number:	
_____	_____	
Insurance Address:	Phone:	
_____	_____	
Annual Maximum:	Deductible:	Remaining Amount:
_____	_____	_____

6. WHOM MAY WE THANK

☐ Referred by a friend (Name)	☐ A family member is a guest at our office (Name)	☐ Other: (Please specify)
_____	_____	_____

DENTAL HISTORY

7. How important is it to you that our office practices Holistic and Biological dentistry?

What is the nature of today's visit?
☐ Comprehensive Exam ☐ Consultation ☐ Emergency

Your current dental health is:
☐ Good ☐ Fair ☐ Poor

Braces/Orthodontics
☐ Yes ☐ No

Date and nature of your last dental visit:

Wisdom teeth extractions:
☐ Yes ☐ No

Periodontal Surgery
☐ Yes ☐ No

Last Dental Cleaning:

Last X-rays:

Former Dentist:

Phone:

City:

8. Problems with previous dental work?

☐ Yes ☐ No

9. If yes, please explain:

10.I certify that the above information is correct to the best of my knowledge.

Patient/Guardian Signature:

Signature

Date

CONFIDENTIAL HEALTH HISTORY

11. Your current health is: Please Explain:

12.

	Yes	No	If Yes, Please Explain
Are you being treated by a physician now?	Yes	No	
Has there been any change in your health within the last year?	Yes	No	
Have you gone to the hospital/emergency room or had any serious illness in the past three years?	Yes	No	
Do you have any Drug Allergies?	Yes	No	

13. Please check if you have or had any of the following:

- | | | |
|---|---|---|
| ☐ Abnormal Bleeding | ☐ AIDS/HIV positive | ☐ Alcohol/Drug Abuse |
| ☐ Anaphylaxis | ☐ Anemia | ☐ Arthritis/ Rheumatism |
| ☐ Artificial Bones/Joints | ☐ Artificial Heart Valve | ☐ Asthma |
| ☐ Back/Postural problems | ☐ Bacterial Infections/MRSA | ☐ Bad Breath |
| ☐ Bell's Palsy | ☐ Bleeding Gums | ☐ Blood Disorders |
| ☐ Blood Transfusion | ☐ Cancer | ☐ Cervical Pain |
| ☐ Chemical Dependency | ☐ Chemotherapy/Radiation | ☐ Chest Pain (Angina) |
| ☐ Chronic fatigue | ☐ Clenching or Grinding | ☐ Colitis/Ulcer |
| ☐ Cortisone treatments | ☐ Cosmetic Surgery | ☐ Cough up blood |
| ☐ Cough, persistent | ☐ Dental Anxiety | ☐ Dental Implants |
| ☐ Difficulty Chewing | ☐ Diabetes | ☐ Difficulty Breathing |
| ☐ Difficulty Swallowing
(Dysphasia) | ☐ Discomfort with TMJ | ☐ Dry Mouth |
| ☐ Ear congestion/Itchy | ☐ Eating Disorders | ☐ Emphysema |
| ☐ Epilepsy/Seizures | ☐ Eye Disease | ☐ Facial or Jaw Pain |
| ☐ Fainting Spells | ☐ Fever/Cold Blisters | ☐ Gag Reflex |
| ☐ GERD | ☐ Glaucoma | ☐ Hay Fever |
| ☐ Headaches/Migraines | ☐ Heart Attack/Surgery | ☐ Heart Disease/Defect |
| ☐ Heart Murmur | ☐ Hepatitis | ☐ Herpes |
| ☐ High blood pressure | ☐ Hospitalized | ☐ Insomnia |
| ☐ Jaw Joint Noise/Clicking | ☐ Jaw Joint Pain | ☐ Kidney problems |
| ☐ Latex Sensitivity | ☐ Liver disease | ☐ Loose Teeth |
| ☐ Low Blood Pressure | ☐ Material/Food Allergies | ☐ Medical Implants |
| ☐ Metal Rods/Pins | ☐ Mitral Valve Prolapse | ☐ Nail Biting Habit |
| ☐ Neck and Shoulder Aches | ☐ Nervous/Anxious | ☐ Old or broken fillings |
| ☐ Osteoporosis | ☐ Pacemaker | ☐ Pressure behind eyes |
| ☐ Previous gum treatment | ☐ Psychiatric Care | ☐ Rapid Weight Loss/Gain |
| ☐ Respiratory Disease | ☐ Restricted/Special Diet | ☐ Rheumatic/Scarlet Fever |
| ☐ Ringing in the ear (Tinnitus) | ☐ Sense of Change of Balance | ☐ Sensitive Teeth |
| ☐ Shingles | ☐ Shortness of breath | ☐ Sickle Cell Disease |
| ☐ Sinus Problems | ☐ Skin Disease/Rash | ☐ Sleep Apnea |
| ☐ Spina Bifida | ☐ Stroke | ☐ Swelling of feet or ankles |
| ☐ Thyroid Problems | ☐ Tingling of Fingertips | ☐ Tonsillectomy (have had) |
| ☐ Tonsillitis | ☐ Tuberculosis | ☐ Tumors |
| ☐ Venereal Disease | ☐ Vertigo (Dizziness) | ☐ Worn and/or discolored teeth |

14. What type of Materials or Food are you allergic to? Please explain.

15. Have you had Surgery?

☐ Yes

☐ No

16. If yes, please explain:

17. Weight:

Height:

Do you have any other medical problems not listed on this form?

☐ Yes ☐ No

If Yes, What Type of Medical Problems?

18. Women Only

Are you pregnant?

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

Do you have a history of miscarriages?

☐ Yes ☐ No

If yes, expected delivery date?

Are you taking birth control pills?

☐ Yes ☐ No

Have you reached menopause?

☐ Yes ☐ No

If yes, when?

19. All Patients

	Yes	No	Explain, if needed
Anything you would like to discuss with the doctor in private?	Yes	No	
Do you take antibiotics before dental treatments?	Yes	No	
Are you taking or have taken Fen-phen or Bisphosphonate (Fosamax)?	Yes	No	
Do you use any form of tobacco (e.g. Cigarettes, chew, vape)? How much?	Yes	No	
Do you drink alcohol? How much?	Yes	No	
Are you in pain now?	Yes	No	

20. Family History:

- ☐ Cancer
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ GERD
- ☐ Heart Disease
- ☐ Sleep Apnea
- ☐ Other:

If other, please specify:

21. Please list ALL Prescription/Over the Counter Drugs or Herbal supplements and the dosage you are currently taking.

	Medication/Supplement	Dosage	Reason for taking?
1			
2			
3			
4			

22. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired. This refers to daily life in recent times; if these things have not occurred recently, try to recall how they would have affected you. Check one in each row: 0=No Chance, 1=Slight Chance, 2=Moderate Chance, 3=High Chance

	Chance of Dozing		Chance of Dozing
Sitting and reading		Watching TV	
Sitting inactive in a public place (e.g. A theater or a meeting)		As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit		Sitting and talking to someone	
Sitting quietly after a lunch without alcohol		In a car, while stopped for a few minutes in traffic	

23. Is there anything else about your health or having dental treatment that you would like us to know?

24.NOTE: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand this form. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to notify Dr. Nehawandian of any changes in my health or medications. I will not hold Dr. Nehawandian or any member of her team, responsible for any errors or omissions I may have made in the completion of this form. I understand that if Dr. Nehawandian or her team determine that there may be a potentially compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Patient/Guardian's Signature

Signature

Date

Doctor's Signature

Signature

Date