Top Down Dental
Nancy Nehawandian, DDS, MAGD

GUEST INFORMATION

Last Name:	First Name:	Middle Initial:
Preferred Name:	Age:	□ Male □ Female
Birth date:	Marital Status:	# of Children:
Address:	City:	State: Zip:
Phones: Home:	Work:	Cell:
Email:		
Social Security:		
Employer:	Occupation:	
□ Yes □ No Are you a full time student? If yes, name of School?		
Emergency Contact:		Phone:

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

□ Parent □ Guardian Name:		
Address:	City:	State: Zip:
Social Security:		
Will we be assisting you with insurance? □ Y □ N		

MEDICAL HISTORY

I. Please Answer the following Questions

Your current oral health is: □ Good	□ Fair □ Poor
□ Y □ N Wisdom teeth extractions	□ Y □ N Braces/Orhodontics □ Y □ N Periodontal Surgery
□ Y □ N Problems with previous dental work? Please Explain:	
Your current overall health is □ Good □ Fair □ Poor	Please Explain:
Physician's Name:	Phone: City:
Date and nature of last visit:	Date of Last Physical Exam:
Weight:	Height:
□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 or surgeries in the past three years?
□YES □ NO	Do you have any Drug Allergies?
□YES □ NO	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?
Family History: □Cancer □Dementia/Alzheimer's □Diabetes □GERD □Heart Disease □Sleep Apnea □Other	
Please list ALL Prescription/Over the Counter Drugs or Herbal supplements and the dosage you are currently taking.	

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

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

III. Women Only

□YES □ NO	Are you pregnant? Expected delivery date?
□YES □ NO	Are you nursing?
□YES □ NO	Are you taking birth control pills?
□YES □ NO	Do you have a history of miscarriages? When?
□YES □ NO	Have you reached menopause?

IV. Check the Box if your answer is yes to any of the following questions:

□YES □ NO	Snoring (Do you snore?)
□YES □ NO	Tired (Do you often feel tired, fatigued, or sleepy during the daytime?)
□YES □ NO	Observed (Has anyone observed you stop breathing during your sleep?)
□YES □ NO	Blood Pressure (Do you have or are you being treated for high blood pressure?)
□YES □ NO	BMI (BMI more than 25)
□YES □ NO	Age over 40 years old
□YES □ NO	Neck circumference greater than 16 in (40cm)
□YES □ NO	Gender male
STOP-BANG Scoring Model: High Risk of OSA if answered Yes to three or more items above.	

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

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

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 determines that there may be a potentially compromised situation, medical consultation may be needed prior to commencement of dental treatment.

Patient/Guardian's Signature Date Doctor's Signature Date