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topdown dental
Nancy Nehawandian, DDS
healthy mouth healthy body healthy life

GUEST INFORMATION

1. Please enter your information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Age: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married
○ Domestic Partner ○ Separated
○ Divorced ○ Widowed ○ Minor

# of Children: _____

Address: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____ Social Security: _____

Employer: _____ Occupation: _____

Are you a full time student?
○ Yes ○ No

If yes, name of School? _____

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

Wisdom teeth extractions:
○ Yes ○ No

Braces/Orthodontics
○ Yes ○ No

Periodontal Surgery
○ Yes ○ No

Date and nature of your last dental visit:

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. Physician's Name: _____ Phone: _____ City: _____

Date and nature of last visit: _____ Date of Last Physical Exam: _____

13.

	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	

14. 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
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Difficulty chewing
- ☐ 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

15. What type of Hepatitis?

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

17. Have you had Surgery?

- ○ Yes
- ○ No

18. If yes, please explain:

19. Weight: _____ Height: _____ Do you have any other medical problems not listed on this form?
○ Yes ○ No

If Yes, What Type of Medical Problems?

20. Women Only

Are you pregnant?
○ Yes ○ No

If yes, expected delivery date?

Are you nursing?
○ Yes ○ No

Are you taking birth control pills?
○ Yes ○ No

Have you reached menopause?
○ Yes ○ No

Do you have a history of miscarriages?
○ Yes ○ No

If yes, when?

21. 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	

22. Family History, have any members of your family (blood kin) had:

- ☐ Cancer
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ GERD
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sleep Apnea
- ☐ TMJ Disorder
- ☐ Other:

If other, please specify:

_____

23. 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			

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

_____

_____

_____

_____

TMJ HISTORY

25. Please Answer the following Questions

Do you have a burning or painful sensation in your mouth?	Yes	No
Do you get popping, clicking, or grinding noises when you open or close?	Yes	No
Do you ever awaken with an awareness of your teeth or jaws?	Yes	No
Have you ever been told you grind your teeth during sleep?	Yes	No
Do you trouble opening your mouth widely?	Yes	No
Do you feel your bite is different, unstable or uncomfortable?	Yes	No
Do you feel like your sense of balance has changed?	Yes	No
Do you have nasal congestion or difficulty breathing through your nose?	Yes	No
Have you been diagnosed with migraine or tension headaches?	Yes	No

26. Are you aware of clenching during the daytime? How often? _____
○ Yes ○ No

Does your jaw ever lock open or closed? How often? _____
○ Yes ○ No

Do you take Aspirin, Advil, Tylenol or another pain reliever? How often? _____
○ Yes ○ No

27. Do you or have you had any pain in any of the following areas? (Check all that apply)

☐ Ear ☐ Face ☐ Head
☐ Jaw ☐ Neck ☐ Teeth
☐ None ☐ Other:

If other, please specify:

_____

28. What professional advice or treatment have you had regarding your TMJ, headache or pain conditions/problems?

_____
_____
_____
_____

29.

	Yes	No
If you sought treatment for a TMJ problem, did it help?	Yes	No
Do your jaw problems affect your ability to work?	Yes	No
Has your diet changed due to your jaw problems?	Yes	No
Do you joint noises affect others while eating?	Yes	No

30.

	Yes	No	If yes, specify when
Have you ever been injured in an accident?	Yes	No	
Have you ever had a severe blow to your head?	Yes	No	
Are you aware of stiff neck muscles? (specify how often)	Yes	No	
Have you ever been in traction for a neck injury?	Yes	No	
Have you ever had or been advised to have neck surgery?	Yes	No	
Have you ever been diagnosed with Trigeminal Neuralgia or Bell's Palsy?	Yes	No	

SOCIAL HISTORY

31. How often do you have an alcoholic drink?

How often do you take sedatives?

How often do you consume caffeine?

Do you smoke/use chewing tobacco? How much?

SLEEP, SNORING AND APNEA HISTORY

32. Have you been diagnosed or treated for a sleep disorder?
○ Yes ○ No

When?

Do you become easily fatigued?
○ Yes ○ No

At what time of day?

Do you sleep well?
○ Yes ○ No

How long?

Do you dream?
○ Yes ○ No

How often?

Do you have trouble falling asleep or staying asleep?

○ Falling Asleep ○ Staying Asleep ○ Both

33. Please answer the following

	Yes	No
Do you have problems with insomnia?	Yes	No
Do you snore or have you been told you do?	Yes	No
Do you wake up with a headache?	Yes	No
Have you had chronic sleepiness, fatigue or weariness that you can't explain?	Yes	No
Do you often fall asleep reading or watching television?	Yes	No
Have you fallen asleep during the day against your will?	Yes	No
Have you had to pull off the road while driving due to sleepiness?	Yes	No
Have ever been more irritable and short tempered?	Yes	No
Have you felt that your memory and/or intellect are impaired?	Yes	No
Have you been told that you stop breathing while asleep?	Yes	No

34. About how many times per night do you wake up? _____

What time do you normally go to bed? _____

Get up in the morning? _____

Of the hours you are in bed, about how many hours are you asleep? _____

Would you rate the quality of your sleep as:

○ Good ○ Fair ○ Poor

Present Body weight? _____

Height? _____

The Epworth Sleepiness Scale

35. How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

	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	

STOP-BANG Scoring Model

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

- ☐ Snoring (Do you snore?)
- ☐ Tired (Do you often feel tired, fatigued, or sleepy during the daytime?)
- ☐ Observed (Has anyone observed you stop breathing during your sleep?)
- ☐ Blood Pressure (Do you have or are you being treated for high blood pressure?)

37. High Risk of OSA if answered Yes to two or more items above. (Out of above 4 questions)

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

- ☐ BMI (BMI more than 25)
- ☐ Age over 40 years old
- ☐ Neck circumference greater than 16 in (40cm)
- ☐ Gender male

39. High Risk of OSA if answered Yes to three or more items above. (Out of above 8 questions)

ONLY IF APPLICABLE

40. Have you ever had an evaluation at a sleep center?

- ○ Yes
- ○ No

41. Sleep Center and Location: Sleep Study Date:

What professional advice or treatment have you had regarding your snoring or sleep apnea?

If you sought treatment for a sleep disorder, did it help?
○ Yes ○ No

42. Do you wear a CPAP device successfully during sleeping?

○ Yes
○ No

If yes, how many hours?

43. If you have attempted treatment with a CPAP device, but could not tolerate it, please check below reasons for your difficulty.

☐ Mask Leaks
☐ I was unable to get the mask to fit properly
☐ Discomfort caused by the straps and headgear
☐ Unable to sleep comfortably
☐ Noise disturbs my sleep and/or bed partner's sleep
☐ CPAP restricts movement during sleep/Unconscious need to remove CPAP at night
☐ CPAP does not seem effective
☐ Pressure on the upper lip causes tooth related problems
☐ Latex allergy
☐ Other:

If other, please specify:

CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING TREATMENT

Order: Please number the complaints with #1 being the most important. (List all please)	**Frequency:** Please rate your chief complaint as follows: 1=Occasional 2=Frequent 3=Constant	**Intensity:** Please rate your chief complaint on a scale from 0-10. 0=No pain to 10= Most severe pain

44.

Chief Complaint	ORDER	Frequency	Intensity
Jaw clicking/popping			
Jaw joint noise			
Jaw locking			
Muscle twitching			
Limited mouth opening			
Dizziness			
Generalized Headache (Entire head)			
Frontal Headache (Front of your head)			
Occipital Headache (Back of your head)			
Temporal Headache (In your temples)			
Visual disturbances/blurred vision			
Jaw pain			
Facial pain			
Ear pain			
Back pain			
Eye pain			
Neck pain			
Shoulder pain			
Pain when chewing			
Throat pain			
Ear congestion			
Sinus Congestion			
Ringing in the ears			
Fatigue			
Frequent heavy snoring			
Snoring which affecting sleep of others			
Significant daytime drowsiness			

Stop breathing when sleeping			
Difficulty falling sleep			
Gasping when waking up			
Nighttime choking spells			
Feeling un refreshed upon waking			
Morning hoarseness			
Swelling in ankles or feet			

Please Answer the Following Questions

45. When did your symptoms first start?

Was there a specific incident, accident or injury that seemed to trigger your symptoms?

Do your present symptoms affect relationships with family and friends? If so, how?

What are your expectations in seeking treatment at this time?

What do you see yourself doing, after treatment that you are not able to do now?

ONLY IF APPLICABLE

46. Are you involved in a lawsuit regarding your condition?

- ○ Yes
- ○ No

47. If you have an attorney representing you, please complete the following:

Attorney's/Paralegal Name: Phone Number:

Address:

OTHER PROFESSIONALS

To better coordinate your treatment, please list the professionals you have consulted regarding your present symptoms. Please be sure to list primary physician and family dentist. Please initial if you want us to send them a report from your visit.

48.

	Name	Phone		Name	Phone
FAMILY PHYSICIAN			DENTIST		
CHIROPRACTOR			PHYSICAL THERAPIST		
EAR, NOSE AND THROAT			CARDIOLOGIST		
ALLERGIST			NEUROLOGIST		
PSYCHIATRIST			PSYCHOLOGIST		
SLEEP SPECIALIST			OTHER:		

If other, specify type:

_____

49. 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.

Doctor's Signature

_____ _____

Signature Date

Patient /Guardian Signature:

_____ _____

Signature Date