Pre med? Yes/No Reason_____

doolin · haddad
ADVANCED DENTISTRY
www.rochesteradvanceddentistry.com
Phone: (248) 656-2020

Patient Name _____ Date of Birth _____ Email_____

Address_____ Home Phone _____ Cell Phone_____

Spouse's Name or Parent if Minor_____ Contact Phone #_____

Emergency Contact_____ Contact Phone #_____

Primary Dental Insurance _____ Employer _____

Subscriber Name_____ SS# _____ Date of Birth _____

Secondary Dental Insurance _____ Employer _____

Subscriber Name_____ SS# _____ Date of Birth _____

Primary Physician's Name_____ Physician Phone # _____Date of Last Physical_____

Place a mark on "yes" or "no" to

ADD/ADHD	❑Yes	❑No	Glaucoma	❑Yes	❑No	Swollen Feet or Ankles	❑Yes	❑No
AIDS/HIV	❑Yes	❑No	Heart Lesions	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No
Anemia	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Thyroid Problems	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Heart Problems	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No			
Artificial Joints	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Asthma	❑Yes	❑No	Kidney Disease	❑Yes	❑No	Tumor or growth on		
Bleeding abnormally,	❑Yes	❑No	Liver Disease	❑Yes	❑No	Head/Neck	❑Yes	❑No
with extractions or surgery			Mitral Valve Prolapse	❑Yes	❑No			
Blood Disease	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Ulcer	❑Yes	❑No
Cancer	❑Yes	❑No	Pacemaker	❑Yes	❑No			
Chemotherapy	❑Yes	❑No	History Infective Carditis	❑Yes	❑No	Do you use tobacco	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	products?		
Cortisone Treatments	❑Yes	❑No	Radiation Treatment	❑Yes	❑No			
Cough, persistent	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	History of head/neck	❑Yes	❑No
Diabetes	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Radiation?		
Epilepsy	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Date of last dental cleani		
Fainting or dizziness	❑Yes	❑No	Stroke	❑Yes	❑No			

List any medications you are currently taking: Please include any blood thinning medications or aspirin.

_____

_____

List any allergies to medications or other substances, such as latex, etc.

_____

Have you taken or currently taking medications for osteoporosis known as bisphosphonates for example Fosamax, Actonel, or Boniva?

____yes ____no List Medication _____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

The undersigned acknowledges receipt of a copy of the currently effective notice of Privacy Practices for the is healthcare facility. To obtain a copy or review the Notice of Privacy Practices, please visit: www.rochesteradvanceddentistry.com/pdf/new-patient-forms-adult.pdf. A copy of this signed, dated document shall be as effective as the original.

_____ _____

Please print your name Please sign your name

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION (this includes step parents, grandparents and any caretakers who can have access to this patient's records):

_____ _____

Name Relationship

_____ _____

Signature: _____ Date: _____

By signing, I understand that Doolin Haddad may photograph or video certain procedures for in-office educational purposes as well as for proper communications with our specialized laboratories.

Musculoskeletal Screening Questionnaire

DATE _____ DATE OF BIRTH_____

NAME _____

One or more of the following symptoms may be indicative of Musculoskeletal Dysfunction of the head and neck. If you have any of the following symptoms, please indicate by marking the appropriate letters and, if appropriate, marking left or right. (L = Left R = Right)

a. Headaches ___ L R ___
if yes, when are they worse?
Morning ___ Throughout the day ____
b. Pain around eyes ___ L R ___
c. Pain in jaw joints ___ L R ___
d. Pain in lower jaw ___ L R ___
e. Pain in upper jaw ___ L R ___
f. Pain in neck ___ L R ___
g. Pain in shoulder ___ L R ___
h Pain in forehead ___ L R ___
i. Pain in sinuses ___ L R ___
j. Pain in temples ___ L R ___
k Clicking, snapping, grating or popping sound in joint (underline which sounds most descriptive.)
If present, where? ____L R ___
l. Dizziness (vertigo) ____Yes No ___

m. Subjective hearing loss ____Yes No ___

n. Ringing sound in ears ____L R ____
(tinnitus)
o. Fullness, pressure ____L R ____
blockage in ear

p. Pain in tongue ___L R ___

q Limited mouth opening ___Yes No___
r. Difficulty chewing ___Yes No___
s. Difficulty swallowing ___Yes No___
t. Snoring ___Yes No___
u. Repeated awakening at night ___Yes No___
v. Constantly tired ___Yes No___
w. Mouth breathe at night ___Yes No___
x. Awaken with a dry mouth ___Yes No___
If yes, a) Frequently ___
b) Rarely ___
c) Never ___
y. Have you ever been told you stop breathing at night? ___Yes No___
z. Do you have numbness or tingling in the fingertips? ___Yes No___

1. **What are your chief concerns? List from most to least important.**

_____

_____

_____

_____

2. What percentage of resolution of pain would be acceptable to you? _____

3. Has a previous dentists told you about your TMJ issues? Yes ___ No___
   a. Have you had TMJ surgery in the past? Yes ___ No___

4. Has your bite ever been adjusted by a dentist? Yes ___ No___
   If yes, please explain and when _____

5. Have you had teeth removed for orthodontics? Yes ___ No___

6. Have you had your wisdom teeth removed? Yes ___ No___

7. Did you have allergies as a child? Unknown ___ Yes___

8. Have you had your tonsils and/or adenoids removed? Yes ___ No___

9. Do you have a history of migraines or other types of headaches? Yes___ No___

10. Do you know if you clench or grind your teeth? Yes___ No___

11. Have you ever been told that you grind your teeth at night while sleeping? Yes___ No___

12. Have you ever been diagnosed with sleep apnea or other sleep breathing disorder? Yes ___ No___

    If yes:
    a. MILD_____ MODERATE_____ SEVERE_____UNKNOWN_____
    b. Did you have a sleep study? Yes __ No __ When? _____
    c. Do you wear a CPAP? Yes __ No __ Couldn't tolerate __

13. Do you chew gum?
    Frequently ___ Moderately ___ Infrequently ___ Never ___

14. Have you ever been involved in an accident or injury (including: sports injury, serious slips or falls, ski accidents, etc?)

    _____

    When? _____

    What happened? _____

15. Please list chronologically; names and types of doctors (ENT, Neurologist, Chiropractor) and their locations, whom you have seen in the past for any dentally or medically, related problems.

    a. _____

    b. _____

    c. _____

    d. _____

    e. _____

16. Please write in any other pertinent information that has not been covered previously.

    _____

    _____

    _____

Patient Signature _____ ***Date*** _____

Doctor Name _____ ***Date*** _____

Address _____ ***City*** _____ ***Zip*** _____

Telephone _____