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

Pre-med? Yes No
Reason: _____

Patient Name _____ Address w/ZIP _____

Employer _____ Home Phone # _____ Cell Phone # _____

Email _____ SSN # _____

Physician's Name _____ Physician's Phone # _____

Date of Last Physical _____ Date of Birth _____

Spouse's Name _____ Spouse's Phone # _____

Emergency Contact _____ Emergency Contact's Phone # _____

***Place a mark on "yes" or "no" to each:***

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ADD/ADHD | ❑Yes ❑No | Heart Lesions | ❑Yes ❑No | Thyroid Problems | ❑Yes ❑No |
| AIDS/HIV | ❑Yes ❑No | Heart Murmur | ❑Yes ❑No | Tonsillitis | ❑Yes ❑No |
| Anemia | ❑Yes ❑No | Heart Problems | ❑Yes ❑No | Tuberculosis | ❑Yes ❑No |
| Arthritis, Rheumatism | ❑Yes ❑No | Hepatitis Type _____ | ❑Yes ❑No | Tumor or growth on | |
| Artificial Heart Valves | ❑Yes ❑No | High Blood Pressure | ❑Yes ❑No | head or neck | ❑Yes ❑No |
| Artificial Joints | ❑Yes ❑No | Kidney Disease | ❑Yes ❑No | Ulcer | ❑Yes ❑No |
| Asthma | ❑Yes ❑No | Liver Disease | ❑Yes ❑No | | |
| Bleeding abnormally with | | Mitral Valve Prolapse | ❑Yes ❑No | Headaches | ❑Yes ❑No |
| extractions or surgery | ❑Yes ❑No | Nervous Problems | ❑Yes ❑No | Jaw Pain | ❑Yes ❑No |
| Blood Disease | ❑Yes ❑No | Pacemaker | ❑Yes ❑No | Jaw Popping | ❑Yes ❑No |
| Cancer | ❑Yes ❑No | History Infective Carditis | ❑Yes ❑No | Limited Opening | ❑Yes ❑No |
| Chemotherapy | ❑Yes ❑No | Psychiatric Care | ❑Yes ❑No | Congested Ears | ❑Yes ❑No |
| Circulatory Problems | ❑Yes ❑No | Radiation Treatment | ❑Yes ❑No | Dizziness | ❑Yes ❑No |
| Cortisone Treatments | ❑Yes ❑No | Rheumatic Fever | ❑Yes ❑No | Ringing Ears | ❑Yes ❑No |
| Cough, Persistent | ❑Yes ❑No | Scarlet Fever | ❑Yes ❑No | Posture Problems | ❑Yes ❑No |
| Diabetes | ❑Yes ❑No | Sinus Trouble | ❑Yes ❑No | Clenching | ❑Yes ❑No |
| Epilepsy | ❑Yes ❑No | Stroke | ❑Yes ❑No | Grinding | ❑Yes ❑No |
| Fainting or dizziness | ❑Yes ❑No | Swollen Feet or Ankles | ❑Yes ❑No | Facial Pain | ❑Yes ❑No |
| Glaucoma | ❑Yes ❑No | Swollen Neck Glands | ❑Yes ❑No | Bell Palsy | ❑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 are currently taking medications for osteoporosis, known as bisphosphonates** (for example, Fosamax, Actonel, or Boniva)**?**

❑Yes ❑No List Medication**:** _____

**Have you…?**

| | |
|---|---|
| Seen an orthodontist | ❑Yes ❑No |
| Had your bite adjusted | ❑Yes ❑No |
| Had any bite-related treatment | ❑Yes ❑No |
| Had TMJ joint surgery | ❑Yes ❑No |

**Have you ever seen a(n)…?**

| | |
|---|---|
| ENT Professional | ❑Yes ❑No |
| Chiropractor | ❑Yes ❑No |
| Neurologist | ❑Yes ❑No |
| Massage Therapist | ❑Yes ❑No |

**Have you ever had Botox or facial fillers?** ❑Yes ❑No

**Do you use a CPAP or had a sleep study?** ❑Yes ❑No

**Have you had radiation on the head/neck?** ❑Yes ❑No

**Do you use tobacco products?** ❑Yes ❑No

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.

Signature: _____ Date: _____