ALSALEH DENTAL CENTER

**Hani AlSaleh, DMD**
28 Street of Dreams ▪ Martinsburg, WV 25403
Phone: 304-267-8702 Fax: 304-263-2787
www.alsalehdental.com

Welcome to our office. We appreciate your selection of this office to serve your dental health needs. Our goal is to provide the very best possible dental care for our patients so that each of you may maintain optimum dental health throughout your lifetime. Please provide us with the following information so that we may get to know you better.

Date: _____

Name: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Occupation: _____ Company Name: _____

Company Address: _____

By what name do you wish to be called in our office? _____

Birth Date: _____ Marital Status: Widowed Name of Spouse: _____

Whom may we thank for referring you to our office? _____

Other family members in our office: _____

Physician: _____ Address: _____

What in particular brings you to our office? _____

Method of payment: ❑ Payment at time of visit ❑ Credit Card ❑ Dental Insurance

Insurance Company: _____ Name of Insured: _____

Address: _____ Birth Date of Insured: _____

Employer Name: _____ Insured Social Security: _____

Do you have Secondary Dental Coverage?

Insurance Company: _____ Name of Insured: _____

Address: _____ Birth Date of Insured: _____

Employer Name: _____ Insured Social Security: _____

*For our patients with dental insurance, please remember that YOU ARE RESPONSIBLE FOR PAYMENT. Remember too, that few insurance companies attempt to cover all dental costs. Some pay fixed allowances for certain procedures, others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or other balance not paid for by your insurance.*

Next Page

## MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you under a physician's care now? ○Yes ○No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ○Yes ○No If yes, please explain: _____

Have you ever had a serious head or neck injury? ○Yes ○No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ○Yes ○No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ○Yes ○No If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications, pills, or drugs? ○Yes ○No If yes, please explain: _____

Are you on a special diet? ○Yes ○No If yes, please explain: _____

Do you use tobacco? ○Yes ○No If yes, please explain: _____

Do you use controlled substances? ○Yes ○No If yes, please explain: _____

Women: Are you

pregnant/trying to get pregnant? ○Yes ○No Taking oral contraceptives? ○Yes ○No Nursing? ○Yes ○No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs

❑ Other, If yes, please explain: _____

Do you have, or have you had, any of the following?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | ○Yes ○No | Excessive Thirst | ○Yes ○No | Mitral Valve Prolapse | ○Yes ○No |
| Alzheimer's Disease | ○Yes ○No | Fainting Spells/Dizziness | ○Yes ○No | Osteoporosis | ○Yes ○No |
| Anaphylaxis | ○Yes ○No | Frequent Cough | ○Yes ○No | Pain in Jaw Joints | ○Yes ○No |
| Anemia | ○Yes ○No | Frequent Diarrhea | ○Yes ○No | Parathyroid Disease | ○Yes ○No |
| Angina | ○Yes ○No | Frequent Headaches | ○Yes ○No | Psychiatric Care | ○Yes ○No |
| Arthritis/Gout | ○Yes ○No | Genital Herpes | ○Yes ○No | Radiation Treatments | ○Yes ○No |
| Artificial Heart Valve | ○Yes ○No | Glaucoma | ○Yes ○No | Recent Weight Loss | ○Yes ○No |
| Artificial Joint | ○Yes ○No | Hay Fever | ○Yes ○No | Renal Dialysis | ○Yes ○No |
| Asthma | ○Yes ○No | Heart Attack/Failure | ○Yes ○No | Rheumatic Fever | ○Yes ○No |
| Blood Disease | ○Yes ○No | Heart Murmur | ○Yes ○No | Rheumatism | ○Yes ○No |
| Blood Transfusion | ○Yes ○No | Heart Pacemaker | ○Yes ○No | Scarlet Fever | ○Yes ○No |
| Breathing Problem | ○Yes ○No | Heart Trouble | ○Yes ○No | Shingles | ○Yes ○No |
| Bruise Easily | ○Yes ○No | Hemophilia | ○Yes ○No | Sickle Cell Disease | ○Yes ○No |
| Cancer | ○Yes ○No | Hepatitis A | ○Yes ○No | Sinus Trouble | ○Yes ○No |
| Chemotherapy | ○Yes ○No | Hepatitis B or C | ○Yes ○No | Spina Bifida | ○Yes ○No |
| Chest Pains | ○Yes ○No | Herpes | ○Yes ○No | Stomach/Intestinal Disease | ○Yes ○No |
| Cold Sores/Fever Blisters | ○Yes ○No | High Blood Pressure | ○Yes ○No | Stroke | ○Yes ○No |
| Congenital Heart Disorder | ○Yes ○No | High Cholesterol | ○Yes ○No | Swelling of Limbs | ○Yes ○No |
| Convulsions | ○Yes ○No | Hives or Rash | ○Yes ○No | Thyroid Disease | ○Yes ○No |
| Cortisone Medicine | ○Yes ○No | Hypoglycemia | ○Yes ○No | Tonsillitis | ○Yes ○No |
| Diabetes | ○Yes ○No | Irregular Heartbeat | ○Yes ○No | Tuberculosis | ○Yes ○No |
| Drug Addiction | ○Yes ○No | Kidney Problems | ○Yes ○No | Tumors or Growths | ○Yes ○No |
| Easily Winded | ○Yes ○No | Leukemia | ○Yes ○No | Ulcers | ○Yes ○No |
| Emphysema | ○Yes ○No | Liver Disease | ○Yes ○No | Venereal Disease | ○Yes ○No |
| Epilepsy or Seizures | ○Yes ○No | Low Blood Pressure | ○Yes ○No | Yellow Jaundice | ○Yes ○No |
| Excessive Bleeding | ○Yes ○No | Lung Disease | ○Yes ○No | | |

Have you ever had any serious illness not listed above? ○Yes ○No _____

_____

## DENTAL HISTORY

1. Do you desire complete and thorough dental care or treatment of a specific problem only?

   _____

2. Have you had regular preventive dental care in the past? _____
3. When was your last dental appointment? _____
4. Do you feel that saving your teeth is worth the effort? _____
5. Are you satisfied with the appearance of your smile? _____
6. If you could change anything about your smile, what would it be? _____
7. Do you care if metal fillings show? _____
8. Have you ever had orthodontic treatment (braces)? _____
9. Have you ever had wisdom teeth removed? _____
10. Do you wear a removable partial or denture? _____ Year Made: _____
11. If yes, are you satisfied with it? _____
12. Have there ever been any injuries to your mouth? _____
13. Are your gums ever sore or do they bleed? _____
14. Do you have any loose teeth? _____
15. Have you ever been told that you have gum disease (pyorrhea)? _____
16. Do you have any sore or sensitive teeth? _____
17. Do you ever notice sounds or pain in the jaw joint? _____
18. Have you ever been told that you have a problem with your bite? _____
19. Do you clench or grind your teeth? _____
20. Have you ever had any trouble with previous dental treatment? _____
21. Do you have any other concerns that we should know about? _____

    _____

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN: _____ DATE: _____

SIGNATURE OF DOCTOR UPON REVIEW: _____ DATE: _____

## TELL US ABOUT YOU...

The better we understand you, the better we can serve you. We don't like to make assumptions or guess about what makes you tick. Please make a mark along each scale below to indicate your opinion or preference:

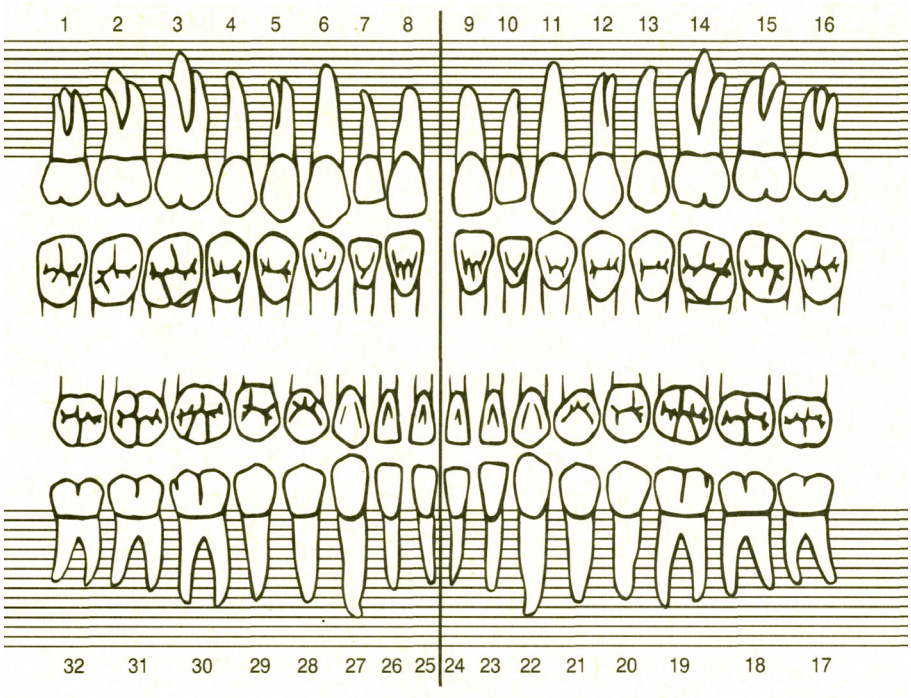
| | |
|---|---|
| I know a great deal about my dental condition | I know very little about my dental condition |
| I like to be presented with fewer options | I like to be presented with more options |
| I tend to look at the details | I tend to look at the big picture |
| I prefer long-lasting solutions which may cost more | I prefer more temporary solutions at lower cost |
| I prefer to talk in technical terms with my dentist | I prefer to talk in non-technical terms |
| I largely determine the extent of my care | My insurance largely determines the extent of my care |
| I usually see no reason to delay care | I prefer to wait until I must act |
| I rely more on self-maintenance | I rely more on professional maintenance |
| I like newer and more modern techniques | I prefer tried and true methods |
| I prefer a preventative and proactive approach to disease | I prefer a "fix it when it hurts" approach to disease |

In order of importance, I generally consider the following **benefits** (please rank 1 through 7 or 8):

| | | | |
|---|---|---|---|
| 8 Comfort | 8 Durability | 8 Precision | 8 Peace of Mind |
| 8 Function | 8 Appearance | 8 Health | 8 Other: _____ |

In order of importance, I generally weigh the following **costs** (please rank 1 through 5 or 6):

6 Money 6 Physical Discomfort 6 Time 6 Fear/Anxiety 6 Personal Effort 6 Other: _____




First Page | Previous Page | Print Form