Emad F. Abdallah, DMD, MS
Member, American Association of Orthodontists
Diplomate, American Board of Orofacial Pain

Patient Name ______________________________ Record Number ____________
First M.I. Last

Address: ______________________________
Street City State Zip Code

Medical Ins. Carrier & No. ____________________ Home Phone ____________

New England Medical Center Reg. No. ____________ Business Phone ____________

Date of Birth: ________ Sex ________ Ht: ____ ft. ____ in. Wt. ____ lbs

Social Security No. ____________ Marital Status: ____________ Occupation: ____________

Name of Spouse: ____________

Person to Call in an emergency: ____________ Phone: ____________

If you are completing this form for another person, what is your relationship to that person?

In this following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.	
1. Do you feel healthy?	☐Yes ☐No
2. Has there been any change in your health within the past year?	☐Yes ☐No
3. My last physical examination was on?	
4. Are you now under care of a physician?	☐Yes ☐No
If so, what is the condition being treated?	
5. The name and address of my physician:	
6. Have you ever had any serious illnesses or operation or have you been hospitalized? If so, what was the illness or operation?	☐Yes ☐No
7. Do you have or have you any of the following illnesses:	
a. Damaged heart valves or artificial heart valves, including heart murmur?	☐Yes ☐No
b. Congenital heart lesions?	☐Yes ☐No
c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary, occlusion, high blood pressure, arteriosclerosis, stroke, congestive heart failure, rheumatic heart Disease) ?	☐Yes ☐No
• Do you have pain in your chest upon exertion?	☐Yes ☐No
• Are you ever short of breath after mild exercise?	☐Yes ☐No
• Do your ankles swell?	☐Yes ☐No
• Do you get short of breath when you lie down? do you need extra pillows when you sleep?	☐Yes ☐No
• Do you have a cardiac pacemaker or defibrillator?	☐Yes ☐No
d. Allergy?	☐Yes ☐No
e. Sinus trouble?	☐Yes ☐No
f. Asthma or hay fever?	☐Yes ☐No
g. Hives or skin rash?	☐Yes ☐No
h. Fainting spells or seizures?	☐Yes ☐No
i. Diabetes?	☐Yes ☐No
• Do you have to urinate (pass water) more than six times per day?	☐Yes ☐No
• Are you thirsty much of the time?	☐Yes ☐No
• Does your mouth frequently become dry?	☐Yes ☐No
j. Thyroid dysfunction?	☐Yes ☐No
k. Hepatitis, jaundice (yellow), or liver disease or cirrhosis?	☐Yes ☐No

l. Arthritis?	☐Yes ☐No
• Do you have a prosthetic joint replacement?	☐Yes ☐No
m. Inflammatory rheumatism (painful swollen joints)?	☐Yes ☐No
n. Osteoporosis?	☐Yes ☐No
o. Stomach, duodenal ulcers or hiatus hernia?	☐Yes ☐No
p. Kidney trouble?	☐Yes ☐No
q. Tuberculosis?	☐Yes ☐No
r. Do you have a persistent cough or cough up blood?	☐Yes ☐No
s. Low blood pressure?	☐Yes ☐No
t. Venereal disease (sexually transmitted disease - STD)?	☐Yes ☐No
u. Epilepsy?	☐Yes ☐No
v. Psychiatric or emotional problems?	☐Yes ☐No
w. Cancer?	☐Yes ☐No
x. Immunosuppressive disorders, HIV/ AIDS?	
8. Have you had any abnormal bleeding associated with the previous extractions, surgery, or trauma?	☐Yes ☐No
a. Do you bruise easily?	☐Yes ☐No
b. Have you ever required a blood transfusion?	☐Yes ☐No
If so, when? Why?	
9. Do you have any blood disorder such an anemia?	☐Yes ☐No
10. Have you had surgery, x-ray or drug treatment for a tumor, growth or other conditions of your head and/or neck ?	☐Yes ☐No
11. Are you taking any drugs, pills, or medications, including:	
a. Antibiotics or sulfa drugs?	☐Yes ☐No
b. Anticoagulants (blood thinners)?	☐Yes ☐No
c. Medicine for high blood pressure?	☐Yes ☐No
d. Cortisone (steroid)?	☐Yes ☐No
e. Tranquilizers/ or anti-depressants/ or anti-psychotic?	☐Yes ☐No
f. Antihistamines?	☐Yes ☐No
g. Anti-asthmatics (inhalers)?	☐Yes ☐No
h. Analgesics (aspirin, ibuprofen, Motrin)?	☐Yes ☐No
i. Digitalis or drugs for heart troubles?	☐Yes ☐No
j. Nitroglycerin?	☐Yes ☐No
k. Oral contraceptive or other hormonal therapy?	☐Yes ☐No
l. Stomach or duodenal ulcer medicine?	☐Yes ☐No
m. Laxatives, diet pills?	☐Yes ☐No
n. Recreational drugs?	☐Yes ☐No
o. Vitamins, non-prescription drugs?	☐Yes ☐No
p. Herbal medications/ supplements?	☐Yes ☐No
q. Other?	☐Yes ☐No
12. Are you allergic or have you reacted adversely to:	
a. Local anesthetics?	☐Yes ☐No
b. Penicillin or other antibiotics?	☐Yes ☐No
c. Sulfa drugs?	☐Yes ☐No
d. Barbiturates, sedatives or sleeping pills?	☐Yes ☐No
e. Aspirin?	☐Yes ☐No
f. Iodine?	☐Yes ☐No

g. Codeine or other narcotics?	☐Yes ☐No
h. Other?	☐Yes ☐No
13. Have you had any serious concerns associated with any previous dental treatment? If so, explain :	☐Yes ☐No
14. Do you have any disease; condition or problem not listed above that you think we should know about? If so, explain:	☐Yes ☐No
15. Are you employed in any situation which exposes you regularly to x-rays / ionizing radiation?	☐Yes ☐No
16. Are you wearing contact lenses?	☐Yes ☐No
17. Do you wear any dental appliances?	☐Yes ☐No
18. Are you or any members of your family in a relationship with anyone who is hurting, or threatening to hurt you or them?	☐Yes ☐No
Women	
19. Are you pregnant?	☐Yes ☐No
20. Are you nursing?	☐Yes ☐No
Chief Dental Complaint (the reason why you are coming):	
1. Date: last dental treatment: / / & last radiographs (x-rays) / /	
2. Frequency, dental visits: Frequency, cleanings:	
3. How often do you brush your teeth (1/day?)	
4. Do you use dental floss?	☐Yes ☐No
5. Do you use fluoridated toothpaste?	☐Yes ☐No
6. Do you use fluoride rinse?	☐Yes ☐No
7. Do you use a mouth rinse or wash?	☐Yes ☐No
8. Do you chew gum?	☐Yes ☐No
9. Do you have or have you had any of the following:	☐Yes ☐No
a. Bleeding, sore gums?	☐Yes ☐No
b. Unpleasant taste/ bad breath?	☐Yes ☐No
c. Burning tongue/ lips?	☐Yes ☐No
d. Blisters, sores, lips, mouth?	☐Yes ☐No
e. Swelling(s), lumps in mouth?	☐Yes ☐No
f. Biting cheeks, lips?	☐Yes ☐No
g. Sensitivity of teeth (hot, cold, sweets, biting)?	☐Yes ☐No
h. Food impaction, catching?	☐Yes ☐No
i. Shifting of teeth, change in bite?	☐Yes ☐No
j. Gum treatment, gum or bone surgery?	☐Yes ☐No
k. Dry mouth	☐Yes ☐No
10. Relating to Temporomandibular Joint disorders (TMJ Disorders), do you have or have had:	
a. Difficulty and/ or pain opening your mouth, such as when yawning?	☐Yes ☐No
b. Your jaw getting “stuck”, “locked” or “going out?”	☐Yes ☐No
c. Difficulty and/ or pain when chewing, talking or using your jaws?	☐Yes ☐No
d. Noises in the jaw joints?	☐Yes ☐No
e. Pain in or about the ears, temples or cheeks?	☐Yes ☐No
f. Soreness of jaw muscles?	☐Yes ☐No
g. Clenching or grinding of your teeth?	☐Yes ☐No
h. An unusual or uncomfortable feeling bite?	☐Yes ☐No

a. Frequent headaches?		☐Yes ☐No
b. Recent injury to your head, neck or jaw?		☐Yes ☐No
c. Treatment for jaw/ joint problem? If yes, when ?		☐Yes ☐No
d. An adjustment to your bite (occlusion)?		☐Yes ☐No
11. Do you drink alcohol? If so, how much per day of week?		☐Yes ☐No
12. Do you use tobacco?		☐Yes ☐No
If so, what type?	How many day per week?	How long?

Patient Signature: ***Date:***

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Dear Prospective Patients,

Thank you for your interest in our services. Please read the following information and sign in the appropriate place.

1. In order to formulate a comprehensive plan for treatment, certain diagnosis procedures will be performed including but not necessary limited to: x-rays, clinical examination of your mouth, impressions of your jaw.

2. Reasonable notice, 24 hours, must be given if you, the patient, are unable to keep an appointment. Failure to cooperate in keeping appointments may disqualify a patient from further treatment.

3. All fees, co-payments and deductibles must be paid at the start of each procedure. No treatment is rendered without charge. Our protocol requires you to pay cash, check or credit card. If you have dental insurance, we will complete the insurance forms so that you will be reimbursed by your carrier. This helps use to keep our fees as low as possible.

4. You are advised that the practice of dental medicine is not an exact science and that no guarantees are being made concerning the results of treatment, procedures or examination at the clinic.

5. In any treatment, allowance must be made for unforeseen and/or unexpected developments. The Most common occurrences which cause major changes in dental treatment estimates are:

    a. Additional periodontal (gum) treatment.
    b. Changes in the materials used.
    c. The need for root canal treatment
    d. A change in the cost of metals.
    e. Annual updating of fees for inflation will be necessary and retro active for procedures not in progress.

MY SIGNATURE BELOW CONSTITUTES MY ACKNOWLEDGEMENT (1) that I have understood the above information. (2) that the procedures have been satisfactorily explained to me and that I have all the information I desire and (3) that I hereby request and give my consent to necessary diagnostic procedures and treatment, including the administration of local and general anesthesia.

Date:__________________
Signature:____

IF PATEINT IS UNDER 18 YEARS, the following must be signed by a parent of legal guardian. To Dr. Emad F. Abdallah, DMD, MS, I hereby apply for dental treatment for:

Patient____ and I authorize treatment including the administration of local or general anesthetic.

Signed:____
Date:__________________________________

Address:____