MARLEN

ELITE DENTAL WELLNESS

Please Help Us Understand You!!!

Patient Name:_____ **Date**_____

Our office is different in that we give our patients our full attention, schedule one patient at a time, find out what is important to them and deliver what we promise. Please answer the following so we can understand you better. Thanks!!!

In your own words, how can we help you?

_____

_____

_____

Are you looking for a new dental home?____yes____no

Do you plan on returning to your old dentist after your treatment is complete? ____yes____no

I am interested in:

___TMJ ___Implants ___Cosmetic/Smile Makeover ___Dentures

___Emergency ___Orthodontics ___ General Dentistry ___ Sleep Apnea

What is your time frame for the above? _____

The first visit is designed to answer your questions as well as to allow you to see if we are the right Dentist for you. If you feel we are not the best Dentist for you, we will be happy to refer you to who we know is a good match for you. If you feel we can help you, we will take records, do a thorough examination and give you specific options for your dental treatment.

Please begin thinking about the following:

> How important are the following concepts: dental health, prevention, dental cosmetics, and facial cosmetics?

We will be discussing this with you shortly.

Thanks Again!!! Marlen Martirossian, DDS

Patient Name_____ Date of Birth_____

Address_____ City, State, Zip_____

Email Address_____ SSN _____

Home Phone#_____ Cell Phone# _____

Employer_____ Work Phone#_____

Spouse Name_____ Spouse Phone#_____

Emergency Contact_____ Contact Phone#_____

Primary Physician's Name_____ Physician Phone#_____

Date of Last Physical_____ Date of Last Dental Cleaning_____

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

ADD/ADHD	❑Yes	❑No	Epilepsy	❑Yes	❑No	Swollen Feet/Ankles	❑Yes	❑No
AIDS/HIV	❑Yes	❑No	Fainting or dizziness	❑Yes	❑No	Swollen Neck Glands	❑Yes	❑No
ANEMIA	❑Yes	❑No	Glaucoma	❑Yes	❑No	Thyroid Problems	❑Yes	❑No
Arthritis, Rheumatism	❑Yes	❑No	Hay Fever/Hives	❑Yes	❑No	Tonsillitis	❑Yes	❑No
Artificial Heart Valves	❑Yes	❑No	Heart Lesions	❑Yes	❑No	Tuberculosis	❑Yes	❑No
Artificial Joints	❑Yes	❑No	Heart Murmur	❑Yes	❑No	Tumor or growth on		
Asthma	❑Yes	❑No	Heart Problems	❑Yes	❑No	Head/Neck	❑Yes	❑No
Autism	❑Yes	❑No	Hepatitis Type _____	❑Yes	❑No	Ulcer	❑Yes	❑No
Bleeding abnormally, with extractions or surgery	❑Yes	❑No	High Blood Pressure	❑Yes	❑No	Sleep Apnea	❑Yes	❑No
			Kidney Disease	❑Yes	❑No			
Blood Disease	❑Yes	❑No	Latex Allergy	❑Yes	❑No	Headaches	❑Yes	❑No
Blood Transfusion	❑Yes	❑No	Liver Disease	❑Yes	❑No	Jaw Pain	❑Yes	❑No
Cancer	❑Yes	❑No	Mitral Valve Prolapse	❑Yes	❑No	Jaw Popping	❑Yes	❑No
Chemotherapy	❑Yes	❑No	Nervous Problems	❑Yes	❑No	Limited Opening	❑Yes	❑No
Circulatory Problems	❑Yes	❑No	Pacemaker	❑Yes	❑No	Congested Ears	❑Yes	❑No
Cold Sores/Fever Blisters	❑Yes	❑No	Parkinson's Disease	❑Yes	❑No	Dizziness	❑Yes	❑No
Congenital Heart Disease	❑Yes	❑No	Psychiatric Care	❑Yes	❑No	Ringing Ears	❑Yes	❑No
Contact Lenses	❑Yes	❑No	Radiation Treatment	❑Yes	❑No	Posture Problems	❑Yes	❑No
Cortisone Treatments	❑Yes	❑No	Rheumatic Fever	❑Yes	❑No	Clenching	❑Yes	❑No
Cough, persistent	❑Yes	❑No	Scarlet Fever	❑Yes	❑No	Grinding	❑Yes	❑No
Diabetes	❑Yes	❑No	Sickle Cell Disease	❑Yes	❑No	Facial Pain	❑Yes	❑No
Diet (special/restricted)	❑Yes	❑No	Sinus Trouble	❑Yes	❑No	Neck Ache	❑Yes	❑No
Emphysema	❑Yes	❑No	Stroke	❑Yes	❑No	Bell's palsy	❑Yes	❑No

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

_____

_____

Are you allergic to any medications or other substances?

_____

_____

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

____yes_____no List Medication_____

Do you pre-medicate for dental procedures?____yes_____no

Circle if you have seen: **an Orthodontist -had your bite adjusted- had any bite related treatment - TMJ Joint Surgery**

Circle if you have seen any of the following healthcare professionals: **ENT, Neurologist, Chiropractor, or Massage Therapist.**

Have you ever had **Botox** and/or **Facial Fillers**?_____yes_____no

Do you snore, use a CPAP or had a sleep study?_____yes_____no

Have you had radiation to the head and/or neck?____yes_____no

Do you use tobacco products?_____yes_____no

Signature:_____ Date:_____

What We Believe All Patients Deserve

1. To be given a full dental assessment & treatment plan, both when new to the practice, and periodically thereafter, so that each patient may accomplish the level of dental health and aesthetics that they want to achieve.

2. To be treated with the respect and dignity in a guilt free environment, especially related to any dental health issues the patient is now experiencing.

3. To have all treatment completed in a comfortable manner; to have options for sedation by Nitrous Oxide (laughing gas), sedation by pill form, or more complete sedation as needed.

4. To be seen on time and to never be required to wait.

5. To have all treatment completed on time in the least amount of appointments possible.

6. To have access to the best materials, laboratories, technology, and techniques available in dentistry today.

7. For patients with dental insurance, all treatment to be driven and guided for the benefit of the patient and not for the benefit of the insurance company and for the dental office to file all paperwork and explain all dental benefits to patient.

8. To receive multiple payment options as well as long term payment plans and for all cost of treatment to be fully explained and in writing

9. To receive a guarantee, both in terms of results and in terms of time guarantees.

10. For the dental office to be available for fast and expedient emergency treatment 24 hours a day, 7 days a week.