Synergycentre Dental & Healthcare

Dr. Maria Tetelbaum
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Beauty within
Helping you look as young as you feel

Welcome to the office of Dr. Maria Tetelbaum at Synergy Centre Dental & Healthcare.
In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire.
All information is strictly confidential and for our records only.

PERSONAL HISTORY

Date:_____

Last Name: _____ First Name: _____

Date of Birth: D _____M _____YR _____ **Age**: _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Preference of which number to call you: *(please circle)* HOME / CELL / WORK **May we leave a voicemail? YES / NO**

***Email:** _____ Occupation: _____

How did you hear about us? *(please circle)*

Friend or Family Facebook/Instagram Website Advertisement Physician/Healthcare Professional

Signage on building/Driving by Email Google Search Other: _____

MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you planning a **pregnancy** within the next year? **YES / NO**

Major illnesses or Surgeries [PAST or PRESENT] (cancer, diabetes, surgery, etc.) _____

Do you have any **neurological** conditions? [i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, etc.] **YES / NO**

Have you ever had **Bells Palsy? YES / NO**

Do you have any **autoimmune** conditions? [i.e. lupus, psoriasis, rheumatoid arthritis, Crohn's disease, etc.] **YES / NO**

Are you awaiting any surgery/procedure? [eg. joint replacement, colonoscopy, dental implant/cleaning, etc.] **YES / NO**
If yes, please explain:
_____

Please list any **current medications** including vitamins, herbal supplements (dosage not required) _____

_____

Current health conditions/diagnoses (*if not already listed*): _____

_____

Are you taking **blood thinners** [anti-coagulant or anti-platelet medications]? **YES / NO** If yes, please explain: _____

Have you taken Aspirin, Advil, alcohol in the **last 48 hours**? **YES / NO**

Please list any **Allergies** [foods, medication, bee/wasp stings]: _____

Allergic reaction or sensitivity to Lidocaine? [dental freezing]: **YES / NO**

Have you ever had an **anaphylactic** allergic reaction? **YES / NO** If yes, to what? _____

Do you suffer from seasonal / environmental allergies? **YES / NO** Do you suffer from chronic sinus congestion? **YES / NO**

Have you lost significant weight in the last year? [more than 30 lbs] **YES / NO**

Have you been diagnosed with osteoporosis ? **YES / NO** If yes, when? _____

Have you lost any posterior [back] teeth [molars]? **YES / NO** Right side / Left side Any history of gum disease? **Y / N**

SKIN HEALTH & HISTORY

How would you rate the quality of your skin? *(circle)* Poor Fair Good Very Good Excellent

If you could improve your skin, what would focus on? *(circle)* Hydration Elasticity/Tightness Smoothness/Texture Acne
Volume Redness Scarring Pigmentation
OTHER (eg. mole removal, etc): _____

Have you had any **facial surgeries/procedures?** (i.e. facelift, blepharoplasty, skin cancer removal, etc) If so, what? _____

Do you have a history of **keloid** (thick) scarring? **YES / NO**

Do you have a history of hyper-pigmentation/melasma? **YES / NO**

Do you have a history facial ***Herpes Simplex*** (cold sores)? **YES / NO** If yes, date of last outbreak: _____

Do you regularly sun bathe or use tanning beds? **YES / NO** If yes, how often? _____

Do you use SPF/sunscreen/sunblock? **YES / NO** If yes, which product(s)?_____

Do you use any Retinol based products? **YES / NO**

What do you currently use for skincare? *(i.e. cleanser, toner, serum, moisturizer, pharmaceutical grade or drugstore)* _____

_____

COSMETIC TREATMENT HISTORY

Have you previously received cosmetic injection treatments? YES / NO If yes, date of last injection: _____

If yes, please indicate if it was: Botox
Facial Fillers
Other (i.e. PRP, micro-needling, etc): _____

*Any **concerns or complications** from previous treatments? **YES / NO** If yes, please explain: _____

What is the main reason for your visit with us today?

_____

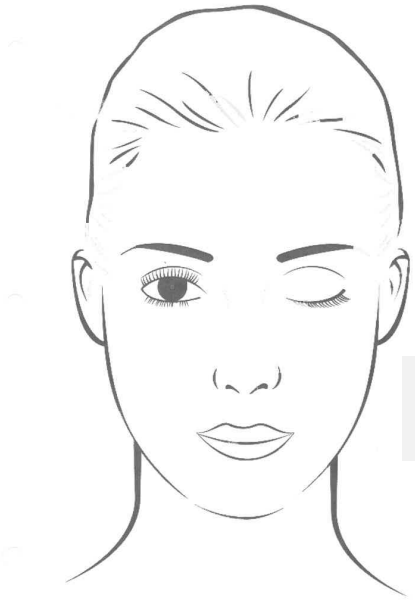
_____

What are the 3 main areas [listing in order] you wish to treat?

1. _____
2. _____
3. _____

Which 3 statements best reflect how you feel about your appearance?
(List in order #1 - #2 - #3)

___ I want to look less tired
___ I want to look less angry
___ I want to look less sad
___ I want a less saggy appearance
___ I want to look more youthful
___ I want to look more attractive
___ I want my face to look slimmer
___ I want to improve my chin profile [double chin]
___ I want softer features



Please circle the area(s) of your interest

You may NOT have Botox, Dermal Fillers or PRP Therapy if you are pregnant, breastfeeding, or during the first three months following delivery.

PLEASE SIGN - AUTHORIZATION OF INFORMATION

I have carefully read all 3 pages of this document and confirm that the above stated/written information and disclosure of my personal health information is correct to the best of my knowledge.

Patient Signature: _____

Print Name: _____

Thank you for choosing ***Beauty Within*** Medical Aesthetics

Thank you for trusting us with your care,

Dr. Maria Tetelbaum & Team

OPTIONAL *Please circle any of the treatments / products below that may also be of interest to you.

SKIN QUALITY	FACIAL IMPROVEMENT	OTHER	DENTAL
Skin Injections [**Juvederm** ® Volite]	Facial/Dermal Fillers [**Juvederm** ®]	Laser Hair Removal	**ZOOM** Teeth Whitening
Skincare Products [Vivier® line]	Wrinkle Relaxers [**Botox** ®]	Scar Revision	**INVISALIGN** Teeth Straightening or Braces
Laser Treatment [for hyperpigmentation, rosacea, skin tightening]	Non-Surgical Facelift [**MD Codes** facelift]	Tattoo Removal	**VENEERS** Cosmetic Dentistry
Chemical Peels	[**Belkyra**®] Under chin fat reduction	Microblading [eyebrows]	Dental implants
Facials	**PRP** [Platelet Rich Plasma] with micro-needling for Face, Neck, Décolleté	Eyelash Extensions	TMJ - jaw clenching
Microdermabrasion	Cosmetic Mole Removal	**Latisse**® Grow your own eyelashes	
Micro-needling	Cryotherapy [freezing] for age spots	**PRP** [Platelet Rich Plasma] Treatment for Hair Loss	
		[**Botox** ®] for Chronic Migraine or Hyperhidrosis [excessive sweating]	

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