DR. OCTAVIAN TETELBAUM DENTIST

Dear Parents/Guardians *In order to provide you with the most appropriate treatment, please complete the following questionnaire.* All information is strictly confidential and for our records only.

Child's Last Name: ______________________________ First Name: ____________________________________
Preferred Name: __________________________ Date of Birth: D________M________YR_______Age: ________

Parent/Guardian Contact Information:

Last Name: ______________________________ First Name: ____________________________________
Address: ____City/Town:_____________________________
Postal Code: _________________ Date of Birth: D________M________YR_______Age: ________
Telephone: (______) ___________________________ Cell: (______) ____________________________________
Work: (______) ____________________________________ Other: (______) ___________________________
Preference of which number to call you: ____________________________ May we leave a message? Y / N
Email: ____
Emergency Contact: _________________________Relationship: ___________________Tel#________________
How were you referred to us? Friend or Family / Facebook / Website / Advertisement / Mail / Physician / Signage / Other: ____

Medical History

AIDS/ HIV	Y / N	Fainting Spells	Y / N	Psychiatric Care	Y / N
Anaphylaxis	Y / N	Fever Blisters	Y / N	Radiation Treatment	Y / N
Anemia	Y / N	Frequent Diarrhea	Y / N	Recent Weight Loss	Y / N
Angina	Y / N	Frequent Headaches	Y / N	Recent Weight Gain	Y / N
Anxiety	Y / N	Hay Fever	Y / N	Renal Dialysis	Y / N
Artificial Heart Valve	Y / N	Heart Pacemaker	Y / N	Rheumatic Fever	Y / N
Asthma	Y / N	Heart Trouble/Disease	Y / N	Scarlet Fever	Y / N
Blood Disease	Y / N	Hemophilia	Y / N	Sickle Cell	Y / N
Blood Transfusion	Y / N	Hepatitis A, B, C	Y / N	Sinus Infections /Trouble	Y / N
Breathing Problems	Y / N	High Blood Pressure	Y / N	Spina Bifida	Y / N
Bruise Easily	Y / N	HPV	Y / N	Stomach Disease	Y / N
Cancer	Y / N	Immunocompromized	Y / N	Stroke	Y / N
Chemotherapy	Y / N	Insomnia	Y / N	Swelling of Limbs	Y / N
Chest Pains	Y / N	Intestinal Disease	Y / N	Thyroid Disease	Y / N
Cold Sores	Y / N	Jaundice	Y / N	Tonsillitis	Y / N
Congenital Heart Disorder	Y / N	Lung Disease	Y / N	Tuberculosis	Y / N
Convulsions	Y / N	Mitral Valve Prolapse	Y / N	Tumors / Growths	Y / N
Cortisone Medicine	Y / N	Muscle Cramps	Y / N	Ulcers	Y / N
Diabetes	Y / N	Motor Vehicle Accident	Y / N	Vertigo	Y / N
Depression	Y / N	Nausea	Y / N	Other: _____________________	
Dizziness	Y / N	Nervousness	Y / N		
Easily Winded	Y / N	Pain in Jaw Joints	Y / N	Women Only :	
Epilepsy/Seizures	Y / N	Panic Attacks	Y / N	Pregnant?	Y / N
Excessive Bleeding	Y / N	Parathyroid Disease	Y / N	Trying to get Pregnant?	Y / N
Excessive Thirst	Y / N	Phobias	Y / N	Taking Birth Control?	Y / N

Are you under a Physician's care now? Y / N If Yes, Please Explain: ________________________________
Hospitalized or had Major Operations? Y / N If Yes, Please Explain: ________________________________
Serious Head or Neck Injury? Y / N If Yes, Please Explain: ________________________________
Taking any Medications, Pills, Drugs? Y / N If Yes, Please Explain: ________________________________
____

Are you on a Special Diet? Y / N If Yes, Please Explain: ________________________________
Do you have any Allergies Y / N If Yes, Please Explain: ________________________________
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Personal Habits or Occurrences

Chew gum?	Y / N	In Past / Currently	Per Day / Week: ______________
Eat Candy?	Y / N	In Past / Currently	Per Day / Week: ______________
Consume Soft Drinks?	Y / N	In Past / Currently	Per Day / Week: ______________
Suck Pacifier, thumb,fingers?	Y / N	In Past / Currently	Per Day / Week: ______________
Bite Nails/Other(ie. pens)?	Y / N	In Past / Currently	Per Day / Week: ______________
Wake up Tired?	Y / N	In Past / Currently	Per Week / Mth: ______________
Low Energy During Day?	Y / N	In Past / Currently	Per Week / Mth: ______________
Trouble Concentrating?	Y / N	In Past / Currently	Per Week / Mth: ______________
Wake Often During Sleep?	Y / N	Times per sleep: ______	Avge Hours of Sleep per night __________

Are there any other habits we should be aware of? Y / N If Yes, Please Explain: __________________________

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How many glasses of water do you consume per day on average? ___________________

How often are you involved in exercise per week? ________ What activities? _______________________________

Please describe to us your eating habits on a daily basis: ____

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List out your medications/ vitamins consumed. Include dose and frequency: _______________________________

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Musculoskeletal Screening

Subjective hearing loss? __ L R __

Clicking, snapping, popping sound in joint? __ L R __

Ringing in ears? __ L R __

Fullness or, pressure blockage in ear? __ L R __

Pain in tongue? Y / N

Limited Mouth Opening? Y / N
If yes, Partially? Severe?
If yes, Constant? Sporadic?

Difficulty chewing? Y / N

Change in chewing? Y / N

Difficulty swallowing? Y / N

Change in swallowing? Y / N

Snoring? Y / N

Constantly tired? Y / N

Mouth Breathe at night? Y / N

Awaken with a dry mouth? Y / N
If yes, Frequently? Rarely?

Tingling in Finger Tips? Y / N

Postural Problems? Y / N

History of Clenching Teeth? Y / N

History of Grinding Teeth? Y / N

Loose Teeth? Y / N

Sensitive Teeth? Y / N
If yes, Constant? Sporadic?
If yes, Hot? Cold? Other?

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 health.
I, _________________________ recognize it is my responsibility to inform Synergy Centre of any changes to my medical history or personal lifestyle that may or may not be relevant to the care received by any of the doctors, or team members of Synergy Centre. I understand that I am encouraged to ask as many questions as required in order for me to decide the course of care I decide to go forward with.

Parent/GuardianPrinted Name: ___________________________________ Signature: _______________________________

Date: _____________________________ Treatment Co/ordinator: ____

Dentist/ Dental Team Notations Only:

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