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: ____

Address: ____City/Town:_____________________________Postal Code: _______________

Telephone: (______) _________________________ Cell: (______) _______________________ Work: (______) __________________________

Preference and permission of which number to call you: (_____) ________________________ May we leave a message? YES _____ NO _____

Date of Birth: D_______M_______YR______Age: _______ Email: ____________________Text____________________________________

Occupation : ____ Are you planning a pregnancy within next 2 years?___________

Do you regularly sun bathe or use tanning salons?____________________________ How often? _______________________________________

Do you have a history of Keloid (thick) scarring? YES ______ NO ______ OTHER CONCERNS:____

How were you referred to us? Friend or Family ___________________ Internet ___________________ Advertisement ____________________

Mail_____________________Physician ______________________________ Sign _________________Other: ___________________________

You may not have Botox, Xeomin, Dysport or Dermal Fillers if you are pregnant, breastfeeding, or during the first three months following delivery.

MEDICAL HISTORY

Family Physician: ______________________________Address:____

Are you currently under the care of a family physician? YES ______ NO ______

If yes please explain: ____

Major illnesses (cancer, diabetes, surgery etc...) ____

Current medications including vitamins, herbal supplements (dosage not required) ____

____

Allergies to any medications? ____

Have you ever had an **allergic reaction or sensitivities** to any of the following?

Foods ________________ Lactose / Dairy _____ Lidocaine (Dental Freezing) _____ Other ____

Are you taking Aspirin or Anticoagulant ? _______YES If yes, please explain: ____

Have you taken Aspirin or Advil in the last 48 hours? _______YES _______ NO

Medical Profile for Injectables and Dermal Fillers

SKIN HEALTH & HISTORY

Do you have any chronic skin conditions ? _______YES If yes, please explain: ____

____

Do you get facial Herpes Simplex (cold sores) ? _______YES

Are you using any facial creams or topical medications that contain Retinol (Retinoic Acid? - eg Tazorac) ______ YES

Do you suffer from ______ Chronic Headaches / Migraines

______ Excessive Sweating - Hyperhydrosis

Have you previously had any of the following aesthetic procedures?

_______ Laser Resurfacing _______ Microdermabrasion _______ IPL _______ Laser Skin Tightening _______ Facial Surgery

If yes, when was the last treatment? ____

Have you had injectable treatment before? ______ YES ______ NO If yes, when was last injection?______________________________________

What filler product was used? _____________________________ What location was it injected? __________________________________

Date of last injectable treatment? ____

Any concerns or complications from previous injectable treatment? ______YES _______ NO

If yes, please explain: ____

SKIN CARE

What are your skin concerns and / or challenges? ____

____

What skin care products are you currently using on your skin?

Daytime ____

Evening ____

Weekly / Special Skin Treatments ____

What do you wish to accomplish by visiting us today? ____

____

I agree that the above information is correct. Date: ____

Patient Signature : ____ Print Name: ____