

# New patient questionnaire

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Are you interested in cosmetics? \_\_\_\_\_

Do you have concerns about metals in your mouth? \_\_\_\_\_

Do you fear dental treatment? \_\_\_\_\_

Do you wish to have dental material compatibility testing done? \_\_\_\_\_

What are your main concerns in decreasing order of priority?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

## Previous dentists:

1. \_\_\_\_\_

Phone Nr. \_\_\_\_\_

2. \_\_\_\_\_

Phone Nr. \_\_\_\_\_

Your reason for changing dentists: \_\_\_\_\_

## Naturopathic practitioners / chiropractors / physicians you see:

1. \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

2. \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

3. \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

## What supplements, herbs, or homeopathic remedies do you take?

## Describe briefly what medical or health conditions you suffer from.

Have you taken bisphosphonates (fosamax, etc.) for osteoporosis treatment anytime in the past? Y  N

## Please check if you presently have, or have had any of the following conditions:

TMJ (jaw-joint) problems

Headaches

Snoring/sleep apnea

Clenching or grinding teeth

Orthodontic therapy

With extraction of 4 sound teeth to create space?

Gum disease

Multiple teeth missing