

WELCOME

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City _____ State _____

Zip _____ E-mail _____

Sex M F Birthdate _____

Married Widowed Single

Separated/ Divorced Child

If child/ Parent or Guardian _____

Employer Name _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Work # _____

Home # _____

Cell # _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone # _____

Phone# _____

DENTAL INSURANCE INFORMATION

Subscribers Name _____

Birthdate _____ SS# or Ins. I.D.# _____

Insurance Co. _____ Group # _____

Ins. Phone# _____

TELL US ABOUT YOURSELF

Reason for today's visit _____

Former Dentist _____ City _____ State _____

Date of last dental visit _____ Last x-rays _____

How often do you brush? _____ Floss? _____

Please circle yes or no to indicate if you have had any of the following:

| | | | | | |
|----------------------------------|-----|-------------------------------|-----|--------------------------------|-----|
| Bad breath | Y N | Dry mouth | Y N | Lip or cheek biting | Y N |
| Bleeding gums | Y N | Fingernail biting | Y N | Loose teeth or broken fillings | Y N |
| Blisters on lips or mouth | Y N | Food collection between teeth | Y N | Mouth breathing | Y N |
| Burning sensation on tongue | Y N | Foreign objects in mouth | Y N | Mouth pain | Y N |
| Chew on one side of mouth | Y N | Grinding teeth | Y N | Orthodontic treatment | Y N |
| Cigarette, pipe or cigar smoking | Y N | Gums swollen or tender | Y N | Pain around ear | Y N |
| Clicking or popping jaw | Y N | Sensitivity to sweets | Y N | | |
| Periodontal treatment | Y N | Sensitivity when biting | Y N | | |
| Sensitivity to cold | Y N | Sore or growth in mouth | Y N | | |
| Sensitivity to hot | Y N | Jaw pain or tiredness | Y N | | |

MEDICAL HISTORY

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

- AIDS Yes No
- Anemia Yes No
- Arthritis, Rheumatism Yes No
- Asthma Yes No
- Back Problems Yes No
- Cancer Yes No
- Chemical Dependency Yes No
- Chemotherapy Yes No
- Circulatory Problems Yes No
- Cortisone Treatments Yes No
- Cough, persistent or bloody Yes No
- Diabetes Yes No
- Emphysema Yes No
- Epilepsy Yes No
- Fainting or dizziness Yes No
- Glaucoma Yes No
- Headaches Yes No
- Heart Problems Yes No
- Hepatitis Type _____ Yes No
- Herpes Yes No

- High Blood Pressure Yes No
- HIV Positive Yes No
- Jaundice Yes No
- Jaw Pain Yes No
- Kidney Disease Yes No
- Liver Disease Yes No
- Low Blood Pressure Yes No
- Nervous Problems Yes No
- Psychiatric Care Yes No
- Radiation Treatment Yes No
- Respiratory Disease Yes No
- Scarlet Fever Yes No
- Shortness of Breath Yes No
- Sinus Trouble Yes No
- Skin Rash Yes No
- Special Diet/Weight Loss Yes No
- Stroke Yes No
- Swollen Feet or Ankles Yes No
- Swollen Neck Glands Yes No
- Thyroid Problems Yes No

- Tonsillitis Yes No
- Tuberculosis Yes No
- Tumors or Growths Yes No
- Ulcer Yes No
- Venereal Disease Yes No

Have you ever had or been diagnosed with:

- Artificial Heart Valves Yes No
- Artificial Joints, Screws, Pins, etc. Yes No
- Bleeding abnormally, with extractions or surgery Yes No
- Blood Disease Yes No
- Congenital Heart Lesions Yes No
- Heart Murmur Yes No
- Hernia Repair Yes No
- Mitral Valve Prolapse Yes No
- Pacemaker Yes No
- Rheumatic Fever Yes No

Have you ever had any complications following dental treatment? Yes No

If yes, please describe _____

Have you ever been hospitalized or do you have any other health concerns? Yes No

If yes, please describe _____

Women: Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

Have you ever taken any of these medications?

- Blood Thinners Yes No
- Coumadin Yes No
- Warfarin Yes No
- Diet Medications Yes No
- Dexfenfluramine Yes No
- Fen-phen Yes No
- Pondimin Yes No
- Redux Yes No
- Levoxyl Yes No
- Synthroid Yes No

Are you allergic to:

- Aspirin Yes No
- Barbiturates Yes No
- Codeine Yes No
- Ibuprofen Yes No
- Latex Yes No
- Local Anesthesia Yes No
- Metals (i.e. gold) Yes No
- Penicillin Yes No
- Other _____

Please PRINT all medications now taking: _____

AUTHORIZATION AND RELEASE

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I OR MY MINOR CHILD EVER HAVE A CHANGE IN HEALTH. I CERTIFY THAT I AND /OR MY DEPENDENT(S) HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO DRS. ATA-ABADI ALL INSURANCE BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE ON ALL INSURANCE SUBMISSIONS. THE ABOVE NAMED DENTIST MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENT FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE _____ DATE _____

DOCTOR'S COMMENTS & UPDATE

DOCTOR'S SIGNATURE _____ DATE _____

MEDICAL ALERTS/ COMMENTS _____