Welcome

Thank you for selecting our dental healthcare team! To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us ~ we will be happy to help.

Patient Information (CONFIDENTIAL)

Date ______________ *SS#* ______________

Name ______________ *Birthdate* ______________ *Home Phone* ______________

Address ______________ *City* ______________ *State* ______ *Zip Code* ______________

Occupation ______________ *Email* ______________ *Cell Phone* ______________

Reason For Today's Visit: ______________

Check Appropriate Box: ☐ *Minor* ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed* ☐ *Separated*

Parent/Guardian's Name ______________ *Phone* ______________

Spouse Name ______________ *In Case of Emergency Contact* ______________ *Phone* ______________

Whom May We Thank for Referring You? ______________

Do you have any of the following diseases or problems? (Check DK if you Don't Know the answer to the question)

Tuberculosis	*Yes*	*No*	*DK*
Persistent Cough greater than a 3 week duration	*Yes*	*No*	*DK*
Cough that produces blood	*Yes*	*No*	*DK*
Been Exposed to anyone with tuberculosis	*Yes*	*No*	*DK*

If you answered yes to any of the 4 items above, please stop and return this form to the receptionist.

Responsible Party

Name of Person Responsible for this Account ______________ *Relationship to Patient* ______________

Home Phone ______________ *Cell Phone* ______________ *Work Phone* ______________

Is this Person Currently a Patient in our Office? ☐ *Yes* ☐ *No*

Dental Benefits Information

Name of Insured ______________ *Relationship to Patient* ______________

Birthdate ______________ *SS#/SIN* ______________

Name of Employer ______________ *Work Phone* ______________

Address of Employer ______________ *City* ______________ *State* ______________ *Zip Code* ______________

Insurance Company ______________ *Group#* ______________ *Policy/ID#* ______________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ ***YES*** ☐ ***NO*** ***IF YES, COMPLETE THE FOLLOWING:***

Name of Insured ______________ *Relationship to Patient* ______________

Birthdate ______________ *SS#/SIN* ______________

Name of Employer ______________ *Work Phone* ______________

Address of Employer ______________ *City* ______________ *State* ______________ *Zip Code* ______________

Insurance Company ______________ *Group#* ______________ *Policy* ______________

Patient Medical History

Physician ______________ Office Phone ______________ Date of Last Exam ______________

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain ______	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, Name/Dosage ______	☐	☐
4. Do you use tobacco? (smoking, snuff, chew, buds) If so, how interested are you in stopping? (Circle Below) Very / Somewhat / Not Interested	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you taking or ever taken Fosomax?	☐	☐

7. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local Anesthetics	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs/Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g.) nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)	☐	☐

	Yes	No
8. Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date ______	☐	☐
If yes, have you had any complications?	☐	☐

9. Women Only:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you have or have you had any of the following:

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous Infective Endocarditis	☐	☐	☐
Damaged Valves in transplant heart	☐	☐	☐
Congenital Heart Disease (CHD)	☐	☐	☐
Unrepaired, Cyanotic CHD?	☐	☐	☐
Repaired CHD (completely) in last 6 mos.?	☐	☐	☐
Repaired CHD with residual defects?	☐	☐	☐

	Yes	No
High/Low Blood Pressure	☐	☐
Heart Disease/Trouble/Attack	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur/ w/Regurgitation	☐	☐
Stroke	☐	☐
Angina/Chest Pains	☐	☐
AIDS or HIV Infection	☐	☐
Anemia	☐	☐
Arthritis	☐	☐
Asthma/Easily Winded	☐	☐
Blood Transfusion	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy / Convulsions	☐	☐
Fainting / Seizures	☐	☐
Frequently Tired	☐	☐
Glaucoma	☐	☐
Hay Fever / Allergies	☐	☐
Heart Murmur	☐	☐
Hepatitis / Jaundice	☐	☐
Kidney Disease	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Mitral Valve Prolapse	☐	☐
Radiation/Chemo Therapy	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles / Ulcers	☐	☐
Swollen Ankles	☐	☐
Thyroid Problem	☐	☐
Other	☐	☐

Patient Dental History

Name of Previous Dentist and Location ______________ Date of Last Exam ______________

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot/cold, sweet/sour liquids/foods?	☐	☐
3. Is your home water supply fluoridated?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening, closing or chewing	☐	☐
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials? If yes, date of placement ______	☐	☐
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐
17. Are you interested in replacing amalgam (silver) fillings?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize taking x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Sanjabi and staff to make a thorough diagnosis of dental needs. I also authorize Dr. Sanjabi and staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I am aware my appointments are my responsibility and I must contact Dr. Sanjabi's office within 48 hours when making changes to my appointments; failure to do so will result in a broken appointment fee starting at $50.

______________ ______________

Patient Signature (or Parent/Guardian if minor) Date

Doctor's Comments ______________

Signature ______________ Date ______________