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_____

PHONE NUMBERS

Work # _____

Home # _____

Cell # _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone # _____

Phone# _____

Whom may we thank for referring you? _____

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	High Blood Pressure	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	HIV Positive	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis, Rheumatism	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Jaw Pain	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Back Problems	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No			
Chemical Dependency	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	**Have you ever had or been diagnosed with:**		
Chemotherapy	☐ Yes	☐ No	Nervous Problems	☐ Yes	☐ No	Artificial Heart Valves	☐ Yes	☐ No
Circulatory Problems	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes	☐ No
Cortisone Treatments	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No	Respiratory Disease	☐ Yes	☐ No	Blood Disease	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	Congenital Heart Lesions	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Shortness of Breath	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Hernia Repair	☐ Yes	☐ No
Fainting or dizziness	☐ Yes	☐ No	Skin Rash	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Special Diet/Weight Loss	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Headaches	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No	Swollen Feet or Ankles	☐ Yes	☐ No			
Hepatitis Type _____	☐ Yes	☐ No	Swollen Neck Glands	☐ Yes	☐ No			
Herpes	☐ Yes	☐ No	Thyroid Problems	☐ 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_____

_____

_____

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