

ATTENTION ALL MAC USERS:

Please print this form and complete it prior to your appointment.
Present the completed form to our front office staff at your dental appointment.

Nazanin Barkhodari, DDS

GETTING TO KNOW YOU AS OUR PATIENT

Date: _____

Patient Name	Social Security Number	Driver's License and State	Birth date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		City	State	Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> widow		Email	Cell Number	Home Phone
Primary Insurance Company:		Group	Subscriber	
Secondary Insurance Company:		Group	Subscriber	
I would like to receive correspondences via: <input type="checkbox"/> Email <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell phone				

Responsible Party

Name	Social Security Number	Home Phone
Home Address	City, State, Zip	Birth date
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widow	Relationship to patient	Driver's License and State
Responsible Person's Employer	Occupation	Work Phone
Business Address	City, State, Zip	

Spouse Information

Spouse's Name	Social Security Number	Birth date
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone
Spouse's Business Address	City, State, Zip	

How did you hear about our office?

<input type="checkbox"/> Referred by a Friend	<input type="checkbox"/> Relative	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Welcome Wagon
<input type="checkbox"/> Other	<input type="checkbox"/> TV/Radio	<input type="checkbox"/> Newspaper Ad	<input type="checkbox"/> Direct Mailing	<input type="checkbox"/> Sign By Building
If you were referred, whom may we thank for referring you?				

Consent for Services

I will answer all health questions to the best of my knowledge. *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Signature	Date
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There will be a charge for cancelling an appointment without 48 hour notice or for failing to show for an appointment. The cancellation fee is based on procedure and procedure time.

I understand and agree to this office policy (initial)

Patient's Dental Health

Why have you come to see us today? (e.g.: pain, checkup, etc.)

Previous Dentist

Last Visit

Date of Last Cleaning

Reasons for Changing Dentists:

Have you had any problem with past dental treatment?

Are you unhappy with the appearance of your teeth? Yes No If Yes, Please tell us why?

Are you nervous about seeing a dentist? Yes No If Yes, Please tell us why?

How often do you brush?

Do you floss?

How often?

Are any of your teeth sensitive to: Hot Cold Sweets Pressure

I clench or grind by teeth during the day or while sleeping. My gums bleed while brushing or flossing. I have had periodontal (gum) treatment.

I prefer tooth-colored fillings. I avoid brushing part of my mouth due to pain. My gums feel tender or swollen.

I have problems eating. I have had orthodontics. I have had a facial or jaw injury.

I want my teeth straighten I want my teeth whiter.

What are your dental priorities?
(e.g. appearance, dental health, financial considerations, etc.)

Patient's Medical History

I consider my Health to be (please check one): Excellent Good Fair Poor

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

01. AIDS/HIV Positive <input type="checkbox"/> Yes <input type="checkbox"/> No	32. Genital Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	63. Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
02. Alzheimer's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	33. Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	64. Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
03. Anaphylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No	34. Hay Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	65. Spina Bifida <input type="checkbox"/> Yes <input type="checkbox"/> No
04. Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	35. Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	66. Stomach/Intestinal Dis. <input type="checkbox"/> Yes <input type="checkbox"/> No
05. Angina <input type="checkbox"/> Yes <input type="checkbox"/> No	36. Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	67. Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
06. Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	37. Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No	68. Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
07. Artificial Heart Value <input type="checkbox"/> Yes <input type="checkbox"/> No	38. Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	69. Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
08. Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	39. Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No	70. Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
09. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	40. Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	71. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	41. Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	72. Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Blood transformation <input type="checkbox"/> Yes <input type="checkbox"/> No	42. Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No	73. Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
12. Breathing Problem <input type="checkbox"/> Yes <input type="checkbox"/> No	43. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	74. Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	44. Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	75. Yellow Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No
14. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	45. Hypoglycemia <input type="checkbox"/> Yes <input type="checkbox"/> No	<p style="text-align: center;">Are Allergic to any of the following?</p> <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Sulfa Drugs / Sulfites / Sulfides <input type="checkbox"/> Penicillin <input type="checkbox"/> Codeine <input type="checkbox"/> Latex, Metals, Plastics <input type="checkbox"/> Local Anesthetics (Novocain) Other Medications? Please list all medications you are currently taking:
15. Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	46. Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	
16. Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	47. Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	
17. Cold Sore/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	48. Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	49. Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
19. Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No	50. Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	
20. Cortisone Medicine <input type="checkbox"/> Yes <input type="checkbox"/> No	51. Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	52. Mitral Value Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No	
22. Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	53. Pain in Jaw Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	
23. Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No	54. Parathyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	
24. Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	55. Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	<p style="text-align: center;">Women</p> <input type="checkbox"/> Are you taking birth control medication? <input type="checkbox"/> Are you or could you be pregnant? <input type="checkbox"/> Are you taking or ever taken Oral Bisphosphonate for Osteoporosis?
25. Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	56. Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	
26. Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	57. Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No	
27. Excessive Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No	58. Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	
28. Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	59. Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
29. Frequent Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	60. Rheumatism <input type="checkbox"/> Yes <input type="checkbox"/> No	
30. Frequent Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	61. Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No	
31. Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	62. Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	

Women

Are you taking birth control medication?

Are you or could you be pregnant?

Are you taking or ever taken Oral Bisphosphonate for Osteoporosis?

Doctor Notes Only:

Physician's Name	Phone
Address	Fax

In the event of an emergency, please contact:

Name	Relationship	Phone
Name	Relationship	Phone
Medical Health Reviewed by:		Patient's Signature
Doctor's Signature		Date
Date		If Patient is a Minor, Parent/Guardian Signature
		Date