Nazanin Barkhodari, DDS GETTING TO KNOW YOU AS OUR PATIENT

Date:

								Du	сс.			
Patient Name		Social Sec	l Security Number Driver's Licer		License and State	d State Birth date				r Female		
Home Address				Ci	ty			State		Zip		
			F			Cilla				DI		
Marital Status Single Married Divorced S	Separated	widow	Email			Cell N	lumb	er	Н	ome Ph	one	
Primary Insurance Company:	separateu	WIGOW		Group		1		Subscri	ber			
Secondary Insurance Company:				Group				Subscri	har			
Secondary madrance company.				Стоир				Subscri	bei			
I would like to receive correspondences via: Email Home Phone Cell phone												
			Respons	ible Par	ty							
Name	Social S	ecurity Number	Hor	lome Phone								
Home Address	City, Sta	ate, Zip	Birt	th date								
Marital S	Relatio	nship to patient	Driv	Priver's License and State								
Single Married Divor	W											
Responsible Person's Employer	Occupa	tion	Wo	Vork Phone								
Business Address	City, Sta	ate, Zip										
			C	<u> </u>								
Snouse's Name			Spouse In				Diet	h data				
Spouse's Name				Social S	Social Security Number			Birth date				
Spouse's Employer	Spouse	's Occupation	Spo	Spouse's Work Phone								
Spouse's Business Address				City, Sta	City, State, Zip							
		How d	id you hear	r about	our office?							
Referred by a Friend Re	lative		Yellow Pages	about	Insurance Pla	n		Welco	me Wag	on		
-	//Radio		Newspaper Ad		Direct Mailing				/ Building			
If you were referred, whom may we thank for												
			Consent f	or Servi	ces							
I will answer all health questions to the best												
After explanation by the doctor, I hereby aut	-			-	•		-					
the doctor may dictate in order to carry ou necessary and advisable by the doctor.	ut these proce	edures. 1 a	aiso authorize ar	ia request i	ne administration o	r any anestne	etics a	and x-ray	s as may	be de	emea	
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							
There will be a charge for cancelling an appo	ointment with	out 48 hoi	ur notice or for fa	ailing to sho	 w for an appointmen	t. The cancell	ation	fee is has	sed on nr	ocedur	e and	
procedure time.	The state of the s	- 30 .0 1100		50 5110	s. an appointmen	The concen	20.011		w 5/1 pi			

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 den	tal trea	tment?										
Are you unhappy with the appea	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) treatments to the day or while sleeping.											tal (gum) traatmant		
I prefer tooth-colored fillings. I have problems eating. I have had orthodontics. I have had orthodontics. I have had orthodontics. I have had orthodontics.										er of swollen.			
I have problems eating.							thodontics. I have had a facial or jaw injury.					r jaw injury.	
I want my teeth straightened I want my teeth whiter.													
What are you dental priorities?	financial	conside	erations etc.)										
(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													
Teonsider my fleath to be (pr	ease che	ck one,		ou ha			iny of the following?				Tun	1 001	
01. AIDS/HIV Positive	Yes	No	32. Genital Herp		Yes	No	63. Sickle Cell Disease	Yes	No		V	Vomen	
02. Alzheimer's Disease	Yes	No	33. Glaucoma		Yes	No	64. Sinus Trouble	Yes	No	Δre		ing birth control	
03. Anaphylaxis	Yes	No	34. Hay Fever		Yes	No	65. Spina Bifida	Yes	No		dication		
04. Anemia	Yes	No	35. Heart Attack	/Failu	re Yes	No	66. Stomach/Intestinal Dis.	Yes	No	Are	you or	could you be pregnant.	
05. Angina	Yes	No	36. Heart Murm	ur	Yes	No	67. Stroke	Yes	No	Are	vou tak	ing or ever taken Oral	
06. Arthritis/Gout	Yes	No	37. Heart Pace N	Иaker	Yes	No	68. Swelling of Limbs	Yes	No			onate for Osteoporosis?	
07. Artificial Heart Value	Yes	No	38. Heart Troubl	le/Dise	ease Yes	No	69. Thyroid Disease	Yes	No	Doctor	Notes	Only:	
08. Artificial Joint	Yes	No	39. Hemophilia		Yes	No	70. Tonsillitis	Yes	No				
09. Asthma	Yes	No	40. Hepatitis A		Yes	No	71. Tuberculosis	Yes	No				
10. Blood Disease	Yes	No	41. Hepatitis B o	or C	Yes	No	72. Tumors or Growths	Yes	No				
11. Blood transformation	Yes	No	42. Herpes		Yes	No	73. Ulcers	Yes	No				
12. Breathing Problem	Yes	No	43. High Blood P	ressur	re Yes	No	74. Venereal Disease	Yes	No				
13. Bruise Easily	Yes	No	44. Hives or Rash		Yes	S No	75. Yellow Jaundice	Yes	No				
14. Cancer	Yes	No	45. Hypoglycem	ia	Yes	No	Are Allergic to any of the following?						
15. Chemotherapy	Yes	No	46. Irregular Hea			No	Aspirin/Ibuprofen						
16. Chest Pains	Yes	No	47. Kidney Probl	lems	Yes	No	Sulfa Drugs / Sulfites / Sulfides						
17. Cold Sore/Fever Blisters	Yes	No	48. Leukemia		Yes	No	Penicillin						
18. Congenital Heart Disorder	Yes	No	49. Liver Disease		Yes	No	Codeine						
19. Convulsions	Yes	No	50. Low Blood Pressu			No	Latex, Metals, Plastics						
20. Cortisone Medicine	Yes	No	51. Lung Disease		Yes	No	Local Anesthetics (Novocain) Other Medications?						
21. Diabetes 22. Drug Addiction	Yes	No No	52. Mitral Value Prola 53. Pain in Jaw Joints		ose Yes Yes	No No							
23. Easily Winded	Yes	No	54. Parathyroid			No	Please list all medications y	(OLL ORO CI	urrontl	v taking:			
24. Emphysema	Yes	No	55. Psychiatric C		Yes	No	riease list all friedications y	ou are ci	unenn	y taking.			
25. Epilepsy or Seizures	Yes	No	56. Radiation Tre			No							
26. Excessive Bleeding	Yes	No	57. Recent Weight Lo										
27. Excessive Thirst	Yes	No	58. Renal Dialysis		Yes	No No							
28. Fainting Spells/Dizziness	Yes	No	59. Rheumatic Fever		Yes	No							
29. Frequent Cough	Yes	No	60. Rheumatism		Yes		Physician's Name					Phone	
30. Frequent Diarrhea	Yes	No	61. Scarlet Fever		Yes No		Address		Fax				
31. Frequent Headaches	Yes	No	62. Shingles		Yes	No							
			In	the e	event of an e	mergeno	y, please contact:						
Name		Phone											
Name Relationship							Phone			T -			
Medical Health Reviewed by: Patient's Signature Date								Date					
							If Patient is a Minor, Paren	f Patient is a Minor, Parent/Guardian Signat				Date	
Doctor's Signature			1	Date									