

WELCOME TO OUR OFFICE

Zahra Kavianpour, DDS, P.C

Please complete all information requested

PATIENT REGISTRATION & MEDICAL/DENTAL HISTORY PATIENT INFORMATION

Last _____ First _____ Middle Initial _____
Today's Date _____ Soc. Sec. # _____ Sex: Male Female
Birthdate _____ Whom may we thank for your referral? _____
Reason For Visit _____
Address: _____ Apt # _____
City _____ State _____ ZIP _____ *E-Mail _____
Cell # _____ Home # _____ Work# _____
Marital Status _____ If Minor, Parent or Guardians Name _____

RESPONSIBLE PARTY INFORMATION

Last _____ First _____ Middle Initial _____
Relationship to Patient _____ Soc. Sec. # _____
Sex: Male Female Marital Status _____ Birthdate _____
Address: _____ Apt # _____
City _____ State _____ ZIP _____ *E-Mail _____
Cell # _____ Home # _____ Work# _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. Name _____
Ins. Address _____
Ins. Phone # _____
Group Plan # _____
Insured Name _____
Date of Birth _____
Policy ID # _____
Employer _____

Secondary Insurance

Ins. Co. Name _____
Ins. Address _____
Ins. Phone # _____
Group Plan # _____
Insured Name _____
Date of Birth _____
Policy ID # _____
Employer _____

PATIENT TREATMENT CONSENT

I authorize the dentist or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the dentist(s) and mutually agreed upon by me. I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy to the dentist. This form also authorizes this practice to submit claim forms and receive payment directly from the insurance carrier with the notation "SIGNATURE ON FILE". I authorize my dentist(s) to release treatment records/X-rays or any other information deemed pertinent to my insurance carrier as necessary or requested.

I agree to be responsible for payment of all services rendered on my behalf and my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all HIPPA and financial policies of this office.

PATIENT/PARENT/GUARDIAN SIGNATURE _____ DATE _____

DENTAL HISTORY

(Circle answer)

1. Do you have a specific dental concern? Yes / No
Describe: _____
2. Do you have Dental Examinations on a routine basis? Last exam date: Yes / No
3. Do you think you have active gum disease? Yes / No
4. Have you had any periodontal (gum) treatments? Yes / No
Describe: _____
5. Do you floss on a routine basis? How often? Yes / No
6. Do your gums ever bleed, feel tender or irritated? Yes / No
Describe: _____
7. Does food catch between your teeth? Yes / No
8. Are your teeth sensitive to hot, cold, sweets or chewing? Yes / No
Describe: _____
9. Do you like your Smile? Why or why not? Yes / No
Describe: _____
10. Do you expect to keep all your teeth for a lifetime? Yes / No
11. Do you hear clicking, or feel discomfort with your jaw? Yes / No
12. Do you clench or grind your teeth? Yes / No
13. Have your past experiences with Dentists been positive? Yes / No
Describe: _____
14. Are you apprehensive about dental treatment? Yes / No
15. Do you smoke or chew tobacco? Frequency? Yes / No
16. Date of last full mouth x-ray (Panoramic or 18 individual films)? _____

MEDICAL HISTORY

(Circle answer)

1. Are you under a physicians care now? Why Yes / No
Physicians Name: _____ Phone: _____
2. Have you ever been hospitalized or any major operations? Yes / No
Describe: _____
3. Ever had any searous injury to your head or neck? Yes / No
Describe: _____
4. Are you taking any medications, pills or drugs? Yes / No
Describe: _____
5. Are you on any special Diet? Yes / No
Describe: _____
6. Date of Last Health Care Exam? What was the exam for?: _____
7. Are you taking Tagament (cimetidine)? How Often? _____ Yes / No
8. Do you take Antacid? Yes / No
9. Are you taking any herbal supplements/medicines? Which ones? _____ Yes / No
10. Are you allergic to any medications or substances? Please circle below if yes. Yes / No
Aspirin Penicillin Erythromycin Latex Codeine Any others: _____
Nitrous Oxide Local Anesthetic _____
11. Are you taking, or have you taken biphosphonate drugs? Indicate below if yes. Yes / No
Fosamax Boniva Actonel Skelid Didronel Any others: _____
IV Aredia IV Zometa _____
12. Women please circle any that apply:
Pregnant Trying to get pregnant Nursing Taking Oral Contraceptives

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Cell # _____
 Home # _____ Work # _____ Email _____

*Do you now have or have you ever had any of the following?
 Please circle appropriate answer. *If yes to any of the starred conditions,
 Please call prior to your appointment...Premedication may be required.*

Heart Disease/Surgery*	Yes / No	Shortness of Breath	Yes / No	Genital Herpes	Yes / No
Heart Murmur*	Yes / No	Frequent Cough	Yes / No	Oral Herpes/Fever Blisters	Yes / No
Mitral Valve Prolapse*	Yes / No	Hay Fever	Yes / No	Drug Dependency	Yes / No
Rheumatic Fever*	Yes / No	Sinus Trouble	Yes / No	Alcoholism	Yes / No
Artificial Heart Valve*	Yes / No	Asthma	Yes / No	Diabetes	Yes / No
Ever taken Fen-Phen?*	Yes / No	Bloody Sputum	Yes / No	Excessive Thirst	Yes / No
Artificial Joint*	Yes / No	Emphysema	Yes / No	Hypoglycemia	Yes / No
Heart Pacemaker	Yes / No	Tuberculosis	Yes / No	Tattoos/Body Piercing	Yes / No
Irregular Heart Beat	Yes / No	Cancer	Yes / No	Stroke	Yes / No
Angina/Chest pain	Yes / No	Radiation Treatments	Yes / No	Epilepsy/Seizures	Yes / No
Heart Attack/Failure	Yes / No	Chemotherapy	Yes / No	Fainting or Dizziness	Yes / No
Congenital Heart Disorder	Yes / No	Liver Disease	Yes / No	Glaucoma	Yes / No
High Blood Pressure	Yes / No	Hepatitis A (Infectious)	Yes / No	Psychiatric Care	Yes / No
Bacterial Endocarditis	Yes / No	Hepatitis B or C	Yes / No	Nervousness/Anxiety	Yes / No
Blood Disease	Yes / No	Night Sweats	Yes / No	Alzheimer's Disease	Yes / No
Anemia	Yes / No	Yellow Jaundice	Yes / No	Migraines/Headaches	Yes / No
Excessive Bleeding	Yes / No	Kidney Problems	Yes / No	Auto-immune Disease	Yes / No
Sickle Cell Disease	Yes / No	Renal Dialysis	Yes / No	Need Premedications?	Yes / No
Hemophilia	Yes / No	Thyroid Disease	Yes / No	Stomach/Intestinal Disease	Yes / No
Leukemia	Yes / No	Arthritis	Yes / No	Ulcers/Colitis	Yes / No
Recent Blood Transfusion	Yes / No	Venereal Disease	Yes / No	Rapid Weight Gain/Loss	Yes / No
Swelling of Limbs	Yes / No	Parathyroid Disease	Yes / No	Frequent Diarrhea	Yes / No
Lung Disease	Yes / No	HIV/AIDS	Yes / No		

Have you ever had any other serious illness not checked above? Describe? _____

To the Best of my Knowledge, all the preceding answers are correct. If there are any changes to my health status or my medications, I shall inform the Dentist and staff at the next appointment.

PATIENT SIGNATURE (PARENT OR GUARDIAN) x _____ Date: ___ / ___ / ___

Reviewed By Doctor (Signature): _____ Date: ___ / ___ / ___