PATIENT INFORMATION

Patient Name:	Birth Date:			Date Created:						
Welcome to our office. We apprecia please complete the following form. been any changes in your health, ple	The i	nformation provided on t	his form is im	por	tant	t to your o				
Today's Date: / / Pa	tient	s Name:					Date of birth:	/	_/_	
Sex: Age: What do you pro										
Home address:						State:	Zip:	_		
Billing address (if different):										
Home phone:										
Driver's license #:										
Employer:										
Spouse's name & phone #:										
Emergency name& phone#(other th										
Primary dental insurance:			Group #	t:				_		
Subscriber's name:		Relation	:		Da	te of birth	n: / /			
SS#:							···,,	-		
Secondary dental insurance:			Group #	t:				_		
Subscriber's name:		Relation			Da	te of birth	n://	_		
SS#:										
Name of y our medical doctor:		Dat	e of last visit	to r	ned	lical docto	or://			
Name of previous dentist:		Da	te of last v isi	t to	der	ntist:	//			
Referred to us by:										
Dental Health History										
How often do you brush?		How often do	you floss?							
Do you feel twinges of pain when yo										
Hot foods or liquids?	Cold fo	oods or liquids?	• Sweets?				• Sours?			
Please answer the following questio	ns									
	Y N]		Y	Ν]			Y	Ν
Are you apprehensive about dental		Are your teeth sensitive?					pain or discomfort affeo	,		
treatment? Do you gag easily?		Do you take fluoride suppleme	onto?			appetite, s activities?	sleep daily routine, or o	ther		
Do you wear dentures?		Are you dissatisfied with the a		<u> </u>		Do you fin	d jaw pain or discomfo			\vdash
		your teeth?					frustrating or depressi			<u> </u>
Does food catch between your teeth?		Do you prefer to save your tee	eth ?			or discom	ke medications or pills f fort (pain relievers, mu antidepressants)?	•		
Have you had problems with previous dental treatment?		Do you want complete dental	care?			-	ve a temporomandibul	ar (jaw)		
Do you chew on only one side of your mouth?		Does your jaw make noise so t you or others?	hat it bothers			-	ve pain in the face, che s, throat, or temples?	eks,		
Do you avoid brushing any part of your		Do you clench or grind your ja	ws frequently?			-	hable to open your mot	uth as		
mouth because of pain? Do your gums bleed easily?		Do your jaws ever feel tired?		-		far as you Are you ay	want? ware of an uncomfortal	ole hite?		<u> </u>
Do your gums bleed when you floss?		Does your jaw get stuck so that	it you can't	\square		-	had a blow to the jaw	one brite:	-	
		open freely?				(trauma)?				<u> </u>
Do your gums feel swollen or tender?		Does it hurt when y ou chew c take a bite?	or open wide to			Are you a smoker?	habitual gum chewer o	г ріре		
Have you ever noticed slow-healing sores in		Do you have earaches or do yo				-	ve earaches or pain in f	front of		
or about your mouth? Do you have difficulty in chewing your food?	\square	symptoms or headaches upon morning	awaking in the			the ears?				

Medical History

Have you ever been hospitalized or had a major operation? Do you use tobacco?	Y N Have you ever had a serious h Do you drink Alcohol?		you on a special diet?
Do you take, or have you take Phen-Fen Actonel	en? N Redux Any other medications containing b	Y N Fosama	
Antibiotics or sulfa drugs Tranquilizers Digitalis or drugs for heart trouble Natural remedies	ave you taken any of the followin Y N Anticoagulants (e.g., Coumad Insulin, Orinase, or similar dru Nitroglycerin Nonprescription drug/supple	in) High bla Ig Aspirin ments	pod pressure medicine
Are you taking any medicatio Women: Are you Pregnant/Trying to get pregna Are you allergic to any of the foll		Provide the set of	Have you reached menopause?
Aspirin Metal Barbiturates, sedati Other Allergies?Yes/No If Y]Acrylic]Local Anesthetics
Do you have, or have you had, a			
	Y N	Y N	Y N Y N
AIDS/HIV Positive	Cortisone Medicine	Hemophilia	Radiation Treatments
Alzheimer's Disease	Diabetes	Hepatitis A	Recent Weight Loss
Anaphylaxis	Drug Addiction	Hepatitis B or C	Renal Dialysis
Anemia	Easily Winded	Herpes	Rheumatic Fever
Angina	Emphysema	High Blood Pressure	Rheumatism
Arthritis/Gout	Epilepsy or Seizures	High Cholesterol	Scarlet Fever
Artificial Heart Valve	Excessive Bleeding	Hives or Rash	Shingles
Artificial Joint	Excessive Thirst	Hypoglycemia	Sickle Cell Disease
Asthma	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Blood Disease Blood Transfusion	Frequent Cough	Kidney Problems	Spina Bifida Stomach/Intestinal Disease
	Frequent Diarrhea	Leukemia Liver Disease	Stroke
Breathing Problems	Frequent Headaches Genital Herpes	Low Blood Pressure	Swelling of Limbs
Bruise Easily Cancer	Glaucoma	Lung Disease	Thyroid Disease
Chemotherapy	Hay Fever	Mitral Valve Prolapse	Tonsillitis
Chest Pains	Heart Attack/Failure	Osteoporosis	Tuberculosis
Cold Sores/Fever Blisters	Heart Attack/Failure	Pain in Jaw Joints	Tumors or Growths
Congenital Heart Disorder	Heart Pacemaker	Parathyroid Disease	Ulcers
	Heart Trouble/Disease	Paratifyroid Disease Psychiatric Care	Venereal Disease
Yellow Jaundice	Shortness of Breath	Skin rashes	Weight Gain or Loss
Taking Heart Medication	Taking Allergy Medication	Back or Neck Pain	Frequent Nose Bleeds
Premedication Required by Physiciar			

Do you have or have you ever had any disease, condition or problem not listed above, that you feel we should know about? If yes, Please explain here: ______

**I authorize Dr. Nima Foroutan & Auxiliaries to perform any necessary services needed during diagnosis and treatment. I also understand that specific procedures are delegated to qualified auxiliaries. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.