PATIENT INFORMATION

Patient Name: Birth Date: Date Created:

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Today's Date: ____/____/____ Patient's Name: _____

Date of birth: ____/____/____ Sex:_____ Age:_____ What do you preferred to be called: _____

Home address:_____ City :_____ State:_____ Zip:_____

Billing address (if different):_____ City :_____ State:_____ Zip:_____

Home phone: _____ Cell:_____ E-mail:_____ Driver's license #:_____ State:_____

SS #:_____ Employer: _____ Occupation:_____ Work Phone:_____

Spouse's name & phone #:_____ Emergency name& phone#(other than spouse):_____

Primary dental insurance:_____ Group #:_____

Subscriber's name:_____ Relation: _____ Date of birth:____/____/____ SS#:_____

Secondary dental insurance:_____ Group #:_____

Subscriber's name:_____ Relation: _____ Date of birth:____/____/____ SS#:_____

Name of y our medical doctor:_____ Date of last v isit to medical doctor:____/____/____

Name of previous dentist:_____ Date of last v isit to dentist:____/____/____

Referred to us by: _____

Dental Health History

How often do you brush? _____ How often do you floss? _____

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids?	◯ Yes ◯ No	Cold foods or liquids?	◯ Yes ◯ No	Sweets?	◯ Yes ◯ No	Sours?	◯ Yes ◯ No

Please answer the following questions:

Are you apprehensive about dental treatment?	◯ Yes ◯ No	Are your teeth sensitive?	◯ Yes ◯ No	Does jaw pain or discomfort affect your appetite, sleep daily routine, or other activities?	◯ Yes ◯ No		
Do you gag easily?	◯ Yes ◯ No	Do you take fluoride supplements?	◯ Yes ◯ No	Do you find jaw pain or discomfort extremely frustrating or depressing?	◯ Yes ◯ No		
Do you wear dentures?	◯ Yes ◯ No	Are you dissatisfied with the appearance of your teeth?	◯ Yes ◯ No	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepresants)?	◯ Yes ◯ No		
Does food catch between your teeth?	◯ Yes ◯ No	Do you prefer to save your teeth?	◯ Yes ◯ No	Do you have a temporomandibular (jaw) disorder (TMD)?	◯ Yes ◯ No		
Have you had problems with previous dental treatment?	◯ Yes ◯ No	Do you want complete dental care?	◯ Yes ◯ No	Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	◯ Yes ◯ No		
Do you chew on only one side of your mouth?	◯ Yes ◯ No	Does your jaw make noise so that it bothers you or others?	◯ Yes ◯ No	Are you unable to open your mouth as far as you want?	◯ Yes ◯ No		
Do you avoid brushing any part of your mouth because of pain?	◯ Yes ◯ No	Do you clench or grind your jaws frequently?	◯ Yes ◯ No	Are you aware of an uncomfortable bite?	◯ Yes ◯ No		
Do your gums bleed easily?	◯ Yes ◯ No	Do your jaws ever feel tired?	◯ Yes ◯ No	Have you had a blow to the jaw (trauma)?	◯ Yes ◯ No		
Do your gums bleed when you floss?	◯ Yes ◯ No	Does your jaw get stuck so that you can't open freely?	◯ Yes ◯ No	Are you a habitual gum chewer or pipe smoker?	◯ Yes ◯ No		
Do your gums feel swollen or tender?	◯ Yes ◯ No	Does it hurt when y ou chew or open wide to take a bite?	◯ Yes ◯ No	Do you have earaches or pain in front of the ears?	◯ Yes ◯ No		
Have you ever noticed slow-healing sores in or about your mouth?	◯ Yes ◯ No	Do you have earaches or do you have any jaw symptoms or headaches upon awaking in the morning	◯ Yes ◯ No	-	◯ Yes ◯ No		
Do you have difficulty in chewing your food?	◯ Yes ◯ No						

Medical History

Please answer the following questions:

Have you ever been hospitalized or had a major operation?	Yes No	Have you ever had a serious head or neck injury?	Yes No	Are you on a special diet?	Yes No
Do you use tobacco?	Yes No	Do you drink Alcohol?	Yes No	Do you use controlled substances?	Yes No

Do you take, or have you taken?

Phen-Fen	Yes No	Redux	Yes No	Fosamax	Yes No
Actonel	Yes No	Any other medications containing bisphos	Yes No		

During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	Yes No	Anticoagulants (e.g., Coumadin)	Yes No	High blood pressure medicine	Yes No
Tranquilizers	Yes No	Insulin, Orinase, or similar drug	Yes No	Aspirin	Yes No
Digitalis or drugs for heart trouble	Yes No	Nitroglycerin	Yes No	Cortisone (steroids)	Yes No
Natural remedies	Yes No	Nonprescription drug/supplements	Yes No		

Are you taking any medications, pills, or drugs not listed above? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant?	Nursing?	Taking oral contraceptives?	Have you reached menopause?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics
Barbiturates, sedatives, or sleeping pil			

Other? If yes

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

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No	Shortness of Breath	Yes No	Skin rashes	Yes No	Weight Gain or Loss	Yes No
Taking Heart Medication	Yes No	Taking Allergy Medication	Yes No	Back or Neck Pain	Yes No	Frequent Nose Bleeds	Yes No
Premedication Required by Physician	Yes No	Wear Contact lenses	Yes No				

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.

Signature of Patient, Parent or Guardian:

X Date:_____