PATIENT INFORMATION

Today's Date _____ __ Married __ Single __ Partnered __ Divorced __ Separated __ Widowed

Name _____ __ M __ F Birthdate ___/___/___ Age ____ SS# _____

What do you prefer to be called? _____

Home Address _____
(City) (State) (Zip)

Home # _____ Cell # _____ Wk # _____

Email Address _____ Best time to reach you _____

Whom may we thank for referring you _____

Other family members seen by us _____

Employer _____ Occupation _____

Employer's Address _____
(City) (State) (Zip)

In Case Of Emergency contact:

Name _____ Relationship _____

Emergency Home # _____ Emergency Work # _____

INSURANCE INFORMATION

Primary Insurance:

Insurance Co. Name _____ Phone # _____ Group # _____

Subscriber Name _____ Subscriber ID# _____ Subscriber DOB _____

Subscriber SS# _____ Your relationship to subscriber _____

Subscriber Employer _____ Employer Phone # _____

Employer Address _____

Secondary Insurance:

Insurance Co. Name _____ Phone # _____ Group # _____

Subscriber Name _____ Subscriber ID# _____ Subscriber DOB _____

Subscriber SS# _____ Your relationship to subscriber _____

Subscriber Employer _____ Employer Phone # _____

Employer Address _____

Medications:

What are you currently taking?

_____

_____

_____

_____

_____

Pharmacy: _____Phone: _____

Allergies:

Aspirin
Barbiturates (sleeping pills)
Codeine
Iodine
Latex
Local Anesthetic (w/epi)_____
Clindamycin _____

Penicillin
Sulfa
Sedatives
Erythromycin
Other (please list)

PATIENT INFORMATION

ARE YOU TAKING ANY OF THE FOLLOWING:

Y / N	Acetaminophen	Y / N	Blood Pressure Medicine	Y / N	Recreational Drugs
Y / N	Antibiotics	Y / N	Cold Remedies	Y / N	Steroids/Cortisone
Y / N	Antihistamines	Y / N	Digitalis/Heart Medicine	Y / N	Thyroid Medicine
Y / N	Aspirin	Y / N	Insulin/Diabetes Drugs	Y / N	Tranquilizers
Y / N	Blood Thinners	Y / N	Nitroglycerin		

Have you ever taken Bisphosphonates? Y / N If yes, when? _____

Have you ever taken Actonel? Y / N Boniva? Y / N Fosamax? Y / N Other: _____

Are you taking any prescription/over -the-counter drugs not listed above? Yes No If yes, please list:

_____

Do you have a current physician? _____

CHECK ANY SYMPTOMS OR CONDITIONS BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

Y / N	AIDS	Y / N	Depression/Nervousness	Y / N	Heart Murmur	Y / N	Polio
Y / N	Anemia	Y / N	Difficulty Swallowing	Y / N	Hoarseness	Y / N	Poor Circulation
Y / N	Arm Pain/Numbness	Y / N	Dizziness/Fainting	Y / N	Indigestion	Y / N	Rapid Heartbeat
Y / N	Arthritis	Y / N	Double Vision	Y / N	Irregular Heartbeat	Y / N	Rheumatic Fever
Y / N	Asthma	Y / N	Excessive Thirst	Y / N	Kidney Disease	Y / N	Ringing in Ears
Y / N	Back Pain/Numbness	Y / N	Emphysema	Y / N	Leg Pain/Numbness	Y / N	Sciatica
Y / N	Bleeding Disorders	Y / N	Epilepsy	Y / N	Liver Disease	Y / N	Shoulder Pain
Y / N	Bleeding Gums	Y / N	Earache	Y / N	Loss of Hearing	Y / N	Sinus Problems
Y / N	Bloating	Y / N	Feet Pain/Numbness	Y / N	Low Blood Pressure	Y / N	Stroke
Y / N	Blood in Urine	Y / N	Fever	Y / N	Migraine Headaches	Y / N	Sweats
Y / N	Bright's Disease	Y / N	Forgetfulness	Y / N	Nausea	Y / N	Thyroid Problem
Y / N	Bruise Easily	Y / N	Frequent Urination	Y / N	Neck Pain/Numbness	Y / N	Tuberculosis
Y / N	Cancer	Y / N	Headache	Y / N	Neuralgia	Y / N	Ulcer
Y / N	Chemical Dependency	Y / N	Heart Disease	Y / N	Nose Bleeds	Y / N	Are you Pregnant?
Y / N	Chest Pain	Y / N	Hepatitis	Y / N	Pacemaker	Y / N	Birth Control Pill
Y / N	Chills	Y / N	High Blood Pressure	Y / N	Persistent Cough	Y / N	Do you smoke?
Y / N	Diabetes	Y / N	HIV Positive	Y / N	Pneumonia	Y / N	How much? ___

Please list any serious medical conditions that you have experienced: _____

NOTES (for Doctor's Use Only):_____

AUTHORIZATIONS

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I hereby authorize Dr. Aghakhani/Dr. Mona Entezam to take x-rays, study models, photograph or any other diagnostic aids deemed appropriate by Dr. Aghakhani/Dr. Entezam to make a thorough diagnosis of my meds. I also authorize Dr. Aghakhani/Dr. Entezam to perform any and all forms of treatment, medication and therapy, that may be indicated and further authorize and consent that Dr. Aghakhani/Dr. Entezam choose and employ such assistance as deemed fit. I also understand that use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made in advance. I further understand that a 1 ½ % finance charge (18% annually) will be added to any balance over 60 days. In the event of default, I (we) agree to pay legal interest of the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature: _____ **Date:** _____

Parent or Responsible Party: _____ **Date:** _____