Welcome

To The Office of Angela Pourghassemi D.M.D.

PATIENT INFORMATION

Date Name (Last, First, Middle Initial)

Social Security # Home Phone Sex M ☐ F ☐ Age

Address City State Zip Code

Email Birthdate Single ☐ Married ☐ Widowed ☐ Divorced ☐

Employer Occupation

Business Address Business Phone

Whom may we thank for referring you?

In case of emergency, whom should we notify Name Cell

PRIMARY INSURANCE

Person responsible for account Birthdate

Relationship to patient. If **SELF** Skip to * Social Security #

Address (if different than patient's) Phone

Email City State Zip Code

Person responsible employed by Occupation

Business address Business Phone

***Insurance Company**

Contract # Group # Subscriber #

Other dependents covered by plan

SECONDARY INSURANCE

Is the patient covered by additional insurance? Yes ☐ No ☐ If NO, skip to **AUTHORIZATION** section below

Subscriber Name (If Yes) Relationship to Patient

Social Security # Birthdate Email

Address (if different than patient's)

City State Zip Code Phone

Subscriber employed by Occupation

Business Address Bus Phone

Insurance Company

Contract # Group # Subscriber #

Other dependents covered by plan

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of my benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

MEDICAL HISTORY

Personal Physician's Name

Physician's Phone

Current Physical Health is: **Good** ☐ **Fair** ☐ **Poor** ☐

Are you currently in the care of a personal physician? **Y** ☐ ☐ **N**

Please explain

Do you use tobacco in any form? **Y** ☐ ☐ **N**

Have you had any metal rods, pins or implants? **Y** ☐ ☐ **N**

Are you taking any prescriptions/over counter drugs? **Y** ☐ ☐ **N**

Please list

Have you ever taken phen-fen, aka redux or pondimin? **Y** ☐ ☐ **N**

If so, when?

Have you ever had any of the following medical ailments?

YES	NO		YES	NO	
☐	☐	Abnormal Bleeding	☐	☐	Hepatitis
☐	☐	AIDS	☐	☐	Herpes/Fever Blisters
☐	☐	Alcohol/Drug Abuse	☐	☐	High Blood Pressure
☐	☐	Anemia	☐	☐	HIV
☐	☐	Arthritis	☐	☐	Hospitalization
☐	☐	Artificial Bones/Joints	☐	☐	Kidney Problems
☐	☐	Asthma	☐	☐	Liver Disease
☐	☐	Blood Transfusion	☐	☐	Low Blood Pressure
☐	☐	Cancer/Chemotherapy	☐	☐	Mitral Valve Problems
☐	☐	Colitis	☐	☐	Pacemaker
☐	☐	Congenital Heart Defect	☐	☐	Psychiatric Problems
☐	☐	Diabetes	☐	☐	Radiation Treatment
☐	☐	Difficulty Breathing	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Emphysema	☐	☐	Seizures
☐	☐	Epilepsy	☐	☐	Shingles
☐	☐	Fainting Spells	☐	☐	Sickle Cell Disease
☐	☐	Frequent Headaches	☐	☐	Sinus Problems
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hay Fever	☐	☐	Thyroid Problems
☐	☐	Heart Attack/Surgery	☐	☐	Tuberculosis (TB)
☐	☐	Heart Murmur	☐	☐	Ulcers
☐	☐	Hemophilia	☐	☐	Venereal Disease

Please list any serious medical condition(s) you have had:

_____

_____

_____

Are you allergic to any of the following?

YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Dental Anesthetics	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Other
☐	☐	Jewelry/Metals			

Please list any other medications you are allergic to.

_____

Women **YES NO**

Are you taking birth control pills? ☐ ☐

If you are pregnant .....Week #

Are you nursing? ☐ ☐

DENTAL HISTORY

Why have you come to the dentist today?

Previous Dentist

Phone Date of last visit

Reason for change

Current Dental Health is **Good** ☐ **Fair** ☐ **Poor** ☐

Bristles on your toothbrush **Hard** ☐ **Med** ☐ **Soft** ☐

Are you currently in pain? **Yes** ☐ **No** ☐

	Yes	No
Do you require antibiotics before dental treatment?	☐	☐
Ever had a problem with past dental work?	☐	☐
Do you floss daily?	☐	☐
Have you ever had gum treatment?	☐	☐
Do your gums ever bleed?	☐	☐
Have you ever had periodontal disease?	☐	☐
Ever had pain/discomfort in your jaw joint (TMJ/TMD)?	☐	☐
Do you have any mobility in your teeth?	☐	☐

Are you sensitive to: Cold ☐ Heat ☐ Sweet ☐ Other ☐

Are you happy with the way your smile looks? ☐ ☐ **Y N**

If not, what would you change?

I have received the dental materials sheet.

Initials Date

I understand that the information I have provided today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the office staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials_____Date _____

Doctor's Comments: _____

_____

_____

Medical History Update

Has there been any change in your health status since your last visit? Y N

If yes, explain _____

Patient's Initials _____ Date _____

Doctor's Initials _____ Date _____

Has there been any change in your health status since your last visit? Y N

If yes, explain _____

Patient's Initials _____ Date _____

Doctor's Initials _____ Date _____

Has there been any change in your health status since your last visit? Y N

If yes, explain _____

Patient's Initials _____ Date _____

Doctor's Initials _____ Date _____