

Welcome

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

PATIENT INFORMATION

Date _____ Name (Last, First, Middle Initial) _____
Social Security # _____ Home Phone _____
Address _____ City _____ State _____ Zip Code _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Divorced
Employer _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
In case of an emergency, whom should we notify? _____ Phone _____

PRIMARY INSURANCE

Person responsible for account _____ Birthdate _____
Relationship to patient _____ Social Security # _____
Address (if different than patient's) _____ Phone _____
City _____ State _____ Zip Code _____
Person responsible employed by _____ Occupation _____
Business address _____ Phone _____
Insurance company _____
Contract# _____ Group# _____ Subscriber# _____
Other dependents covered on plan _____

SECONDARY INSURANCE

Is the patient covered by additional insurance? Yes No
Subscriber Name _____ Relationship to patient _____
Social Security # _____ Birthdate _____
Address (if different than patient's) _____ Phone _____
City _____ State _____ Zip Code _____
Subscriber employed by _____ Occupation _____
Business address _____ Phone _____
Insurance company _____
Contract# _____ Group# _____ Subscriber# _____
Other dependents covered on plan _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorized 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 _____

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 prescription/over the counter drugs? Y N

Please list _____

Have you ever taken phen-fen, also called redux or pondimin? Y N

If so, when? _____

Have you ever had any of the following disease or medical problems?

Y N Abnormal Bleeding	Y N Hepatitis
Y N AIDS	Y N Herpes/Fever Blisters
Y N Alcohol/Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV
Y N Arthritis	Y N Hospitalization
Y N Artificial Bones/Joints/Valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer/Chemotherapy	Y N Mitral Valve Problems
Y N Colitis	Y N Pacemaker
Y N Congenital Heart Defect	Y N Psychiatric Problems
Y N Diabetes	Y N Radiation Treatment
Y N Difficulty Breathing	Y N Rheumatic/Scarlet Fever
Y N Emphysema	Y N Seizures
Y N Epilepsy	Y N Shingles
Y N Fainting Spells	Y N Sickle Cell disease
Y N Frequent Headaches	Y N Sinus Problems
Y N Glaucoma	Y N Stroke
Y N Hey Fever	Y N Thyroid Problems
Y N Heart Attack/Surgery	Y N Tuberculosis (TB)
Y N Heart Murmur	Y N Ulcers
Y N Hemophilia	Y N Venereal Disease

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

Are you allergic to any of the following?

Y N Aspirin	Y N Latex
Y N Codeine	Y N Penicillin
Y N Dental Anesthetics	Y N Tetracycline
Y N Erythromycin	Y N Other
Y N Jewelry/Metals	

Please list any other medications you are allergic to:

Women

Are you taking birth control pills? Y N

Are you pregnant? Week# _____ Y N

Are you nursing? Y N

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

Are you currently in pain? Y N

Do you require antibiotics before dental treatment? Y N

Have you ever had a problem with any previous dental work? Y N

Do you floss daily? Y N

Type of bristles on toothbrush? Hard Med Soft

Have you ever had gum treatment? Y N

Do your gums ever bleed? Y N

Have you ever had periodontal disease? Y N

Have you ever had pain/discomfort in your jaw joint? Y N

TMJ/TMD

Do you have mobility in your teeth? Y N

Are you sensitive to: Heat Cold 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 that I have given 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 _____

Doctors Comments: _____

Medical History Update

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

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

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

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

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

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____