

About You

Name: _____

I prefer to be called: _____

Gender: Male Female

Date of Birth: _____

Social Security Number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____ Ext: _____

Employer: _____

Address: _____

Occupation: _____

Who referred you? _____

Email Address: _____

Insurance Information

PRIMARY INSURANCE

Insurance Co: _____

Address: _____

Phone _____

Group/Member #: _____

Name of Insured: _____

Relationship to patient: _____

Date of Birth of Insured: _____

Social Security # of Insured: _____

Insureds Employer: _____

SECONDARY INSURANCE

Insurance Co: _____

Address: _____

Phone _____

Group/Member #: _____

Name of Insured: _____

Relationship to patient: _____

Date of Birth of Insured: _____

Social Security # of Insured: _____

Insureds Employer: _____

Spouse Information

Name: _____

Date of Birth : _____

Social Security Number: _____

Work Phone: _____ Ext: _____

Employer: _____

Occupation: _____

In Case of Emergency

Please provide the following for a friend or relative not living with you

Name: _____

Relationship to you: _____

Home Phone Number: _____

Work Phone: _____ Ext: _____

Medical History

Name of Doctor: _____

Phone Number: _____

Date of Last Visit: _____

Current Health Status: Good Fair Poor

Do you have a medical condition that requires you to take antibiotics before receiving dental treatment? Yes No

Are You Taking Any of the Following?

- | | |
|---|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Heart Medication |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Oral Diabetes Meds |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antidepressants |
| <input type="checkbox"/> Blood Thinner | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Blood Pressure Med |
| <input type="checkbox"/> Nitroglycerine | <input type="checkbox"/> Thyroid Medication |

Have you ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Mitral Valve Prola |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Diabetes (takes insulin) | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Diabetes (takes oral meds) | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Non-Epileptic Seizures | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Anxiety Attacks |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Lupus |

Please list any other serious medical conditions:

Have you received any of the following treatments?

- | | |
|---|---|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Wear Pacemaker |
| <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Radiation |

Are you allergic to any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Keflex | <input type="checkbox"/> Nitrous Oxide |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Metals |

For Women:

Are you taking birth control pills? Yes No

Are you pregnant? Yes (week# _____) No

Are you nursing? Yes No

Dental History

Reason for visit today?

Do you floss daily? Yes No

Do you brush daily? Yes No

Type of bristles on your toothbrush:

Hard Medium Soft

How often do you replace your toothbrush?

Do you use anything in addition to a brush and floss?

Yes No If yes, what?

Do your gums ever bleed? Yes No

Have you ever been told you have periodontal disease?

Yes No If yes, when? _____

Are your teeth sensitive to any of the following?

Heat Cold Sweet Pressure

Do you experience discomfort in your jaws (TMJ/TMD)?

Yes No

Previous Dentist: _____

Date of Last Visit: _____

Reason for leaving last dentist: _____

Are you happy with the way your smile looks?

Yes No

Is snoring a problem for you/spouse? Yes No

Would you like whiter teeth? Yes No

Authorization

I affirm that the information I have given on this form is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status. I authorize my insurance benefits be paid directly to Dr. Azimi Dental and I understand that I am responsible for the payment of deductibles, co-payments, and any balances not covered by my insurance. I also authorize Dr. Azimi Dental Clinic to release any information required to process my claims. I understand that payment is due at the time of service.

Signature _____

Date _____

Print Form

Send Form