Nazanin Barkhodari, DDS

GETTING TO KNOW YOU AS OUR PATIENT

Date:

Patient Name	Social Security Number	Driver's License and State	Birth date	Gender ○ Male ○ Female

Home Address	City	State	Zip

Marital Status ○ Single ○ Married ○ Divorced ○ Separated ○ widow	Email	Cell Number	Home Phone

Primary Insurance Company:	Group	Subscriber

Secondary Insurance Company:	Group	Subscriber

I would like to receive correspondences via: ☐ Email ☐ Home Phone ☐ Cell phone

Responsible Party

Name	Social Security Number	Home Phone

Home Address	City, State, Zip	Birth date

Marital Status ○ Single ○ Married ○ Divorced ○ Separated ○ Widow	Relationship to patient	Driver's License and State

Responsible Person's Employer	Occupation	Work Phone

Business Address	City, State, Zip

Spouse Information

Spouse's Name	Social Security Number	Birth date

Spouse's Employer	Spouse's Occupation	Spouse's Work Phone

Spouse's Business Address	City, State, Zip

How did you hear about our office?

Referred by a Friend ☐	Relative ☐	Yellow Pages ☐	Insurance Plan ☐	Welcome Wagon ☐
Other ☐	TV/Radio ☐	Newspaper Ad ☐	Direct Mailing ☐	Sign By Building ☐

If you were referred, whom may we thank for referring you?

Consent for Services

I will answer all health questions to the best of my knowledge. *(Initial)*

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Signature	Date

There will be a charge for cancelling an appointment without 48 hour notice or for failing to show for an appointment. The cancellation fee is based on procedure and procedure time.

I understand and agree to this office policy (initial)

Patient's Dental Health

Why have you come to see us today? (e.g.: pain, checkup, etc.)

Previous Dentist	Last Visit	Date of Last Cleaning

Reasons for Changing Dentists:

Have you had any problem with past dental treatment?

Are you unhappy with the appearance of your teeth? ◯ Yes ◯ No If Yes, Please tell us why?

Are you nervous about seeing a dentist? ◯ Yes ◯ No If Yes, Please tell us why?

How often do you brush? | Do you floss? How often?

Are any of your teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Pressure

☐ I clench or grind by teeth during the day or while sleeping.	☐ My gums bleed while brushing or flossing.	☐ I have had periodontal (gum) treatment.
☐ I prefer tooth-colored fillings.	☐ I avoid brushing part of my mouth due to pain.	☐ My gums feel tender of swollen.
☐ I have problems eating.	☐ I have had orthodontics.	☐ I have had a facial or jaw injury.
☐ I want my teeth straightened	☐ I want my teeth whiter.	

What are you dental priorities?
(e.g. appearance, dental health, financial considerations, etc.)

Patient's Medical History

I consider my Health to be (please check one): ◯ Excellent ◯ Good ◯ Fair ◯ Poor

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

01. AIDS/HIV Positive ◯ Yes ◯ No	32. Genital Herpes ◯ Yes ◯ No	63. Sickle Cell Disease ◯ Yes ◯ No
02. Alzheimer's Disease ◯ Yes ◯ No	33. Glaucoma ◯ Yes ◯ No	64. Sinus Trouble ◯ Yes ◯ No
03. Anaphylaxis ◯ Yes ◯ No	34. Hay Fever ◯ Yes ◯ No	65. Spina Bifida ◯ Yes ◯ No
04. Anemia ◯ Yes ◯ No	35. Heart Attack/Failure ◯ Yes ◯ No	66. Stomach/Intestinal Dis. ◯ Yes ◯ No
05. Angina ◯ Yes ◯ No	36. Heart Murmur ◯ Yes ◯ No	67. Stroke ◯ Yes ◯ No
06. Arthritis/Gout ◯ Yes ◯ No	37. Heart Pace Maker ◯ Yes ◯ No	68. Swelling of Limbs ◯ Yes ◯ No
07. Artificial Heart Value ◯ Yes ◯ No	38. Heart Trouble/Disease ◯ Yes ◯ No	69. Thyroid Disease ◯ Yes ◯ No
08. Artificial Joint ◯ Yes ◯ No	39. Hemophilia ◯ Yes ◯ No	70. Tonsillitis ◯ Yes ◯ No
09. Asthma ◯ Yes ◯ No	40. Hepatitis A ◯ Yes ◯ No	71. Tuberculosis ◯ Yes ◯ No
10. Blood Disease ◯ Yes ◯ No	41. Hepatitis B or C ◯ Yes ◯ No	72. Tumors or Growths ◯ Yes ◯ No
11. Blood transformation ◯ Yes ◯ No	42. Herpes ◯ Yes ◯ No	73. Ulcers ◯ Yes ◯ No
12. Breathing Problem ◯ Yes ◯ No	43. High Blood Pressure ◯ Yes ◯ No	74. Venereal Disease ◯ Yes ◯ No
13. Bruise Easily ◯ Yes ◯ No	44. Hives or Rash ◯ Yes ◯ No	75. Yellow Jaundice ◯ Yes ◯ No
14. Cancer ◯ Yes ◯ No	45. Hypoglycemia ◯ Yes ◯ No	
15. Chemotherapy ◯ Yes ◯ No	46. Irregular Heartbeat ◯ Yes ◯ No	
16. Chest Pains ◯ Yes ◯ No	47. Kidney Problems ◯ Yes ◯ No	
17. Cold Sore/Fever Blisters ◯ Yes ◯ No	48. Leukemia ◯ Yes ◯ No	
18. Congenital Heart Disorder ◯ Yes ◯ No	49. Liver Disease ◯ Yes ◯ No	
19. Convulsions ◯ Yes ◯ No	50. Low Blood Pressure ◯ Yes ◯ No	
20. Cortisone Medicine ◯ Yes ◯ No	51. Lung Disease ◯ Yes ◯ No	
21. Diabetes ◯ Yes ◯ No	52. Mitral Value Prolapse ◯ Yes ◯ No	
22. Drug Addiction ◯ Yes ◯ No	53. Pain in Jaw Joints ◯ Yes ◯ No	
23. Easily Winded ◯ Yes ◯ No	54. Parathyroid Disease ◯ Yes ◯ No	
24. Emphysema ◯ Yes ◯ No	55. Psychiatric Care ◯ Yes ◯ No	
25. Epilepsy or Seizures ◯ Yes ◯ No	56. Radiation Treatments ◯ Yes ◯ No	
26. Excessive Bleeding ◯ Yes ◯ No	57. Recent Weight Loss ◯ Yes ◯ No	
27. Excessive Thirst ◯ Yes ◯ No	58. Renal Dialysis ◯ Yes ◯ No	
28. Fainting Spells/Dizziness ◯ Yes ◯ No	59. Rheumatic Fever ◯ Yes ◯ No	
29. Frequent Cough ◯ Yes ◯ No	60. Rheumatism ◯ Yes ◯ No	
30. Frequent Diarrhea ◯ Yes ◯ No	61. Scarlet Fever ◯ Yes ◯ No	
31. Frequent Headaches ◯ Yes ◯ No	62. Shingles ◯ Yes ◯ No	

Are Allergic to any of the following?

- ☐ Aspirin/Ibuprofen
- ☐ Sulfa Drugs / Sulfites / Sulfides
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex, Metals, Plastics
- ☐ Local Anesthetics (Novocain)

Other Medications?

Women

- ☐ Are you taking birth control medication?
- ☐ Are you or could you be pregnant.
- ☐ Are you taking or ever taken Oral Bisphosphonate for Osteoporosis?

Doctor Notes Only:

Please list all medications you are currently taking:

Physician's Name	Phone
Address	Fax

In the event of an emergency, please contact:

Name	Relationship	Phone
Name	Relationship	Phone

Medical Health Reviewed by:

Doctor's Signature Date

Patient's Signature Date

If Patient is a Minor, Parent/Guardian Signature Date

RESET

SUBMIT