



PATIENT INFORMATION:

Date: _____
Patient Name: _____
Home Address: _____
City: _____
State: _____ Zip: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Email: _____
Sex: M [] F []
Marital Status: Married [] Divorced []
Separated [] Single []
Social Security #: _____
Date of Birth: _____
Full Time Student: _____
Driver's License #: _____
Emergency Contact/Relationship: _____
Reason for Visit: _____

MEDICAL INSURANCE INFORMATION:

Date of Birth: _____
MEDICAL INSURANCE INFORMATION
Insured's Name: _____

PERSON RESPONSIBLE FOR ACCOUNT:

[] Same as patient (if so, please check box)
Name: _____
Address: _____
City: _____
State: _____
Social Security #: _____
Cell: _____
Home Phone: _____
Work Phone: _____
Sex: M [] F []
Marital Status: Married [] Divorced [] Separated []
Single []
Date of Birth: _____
Relationship to Patient: _____

DENTAL INSURANCE INFORMATION:

Insured's Name: _____
Insured's Employer: _____
Employer's Address: _____
Insurance Co. Name: _____
Insurance Co. Address: _____
Group# _____ ID # _____ Local # _____
Phone #: _____
Home Phone: _____
Work Phone: _____
Insurance Co. Address: _____
Group# _____ ID # _____ Local # _____
Phone#: _____

MEDICAL HISTORY: (circle any of the following which you have had or have at present)

Bleeding Problems/Hemophilia	Headaches	Alcohol/Drug Abuse
Circulatory Problems	Dizziness	Chronic Diarrhea
High or Low Blood Pressure	Blurred Vision	Unexplained Weight Loss
Stroke	Ringing Ears	Swollen Lymph Glands
Heart Attacks	Anemia	Tiredness/Lethargy
Kidney Disease/Transplants	Fainting Spells	Unhealed Mouth Sores
Cancer or Tumor	Shortness of Breath	Bruise Easily
Radiation Treatments	Painful or Swollen Joints	Emphysema
Asthma	Skin Disease	Hay Fever
Blood Transfusions	Thyroid Disease	Sinus Trouble
Sickle Cell Disease	History of Substance Abuse	Glaucoma
Cortisone Medication	Joint Replacement	Mitral Valve Prolapse
Psychiatric Therapy	Diabetes/Excess Sugar	Osteoporosis

Artificial Heart Valve Pacemaker/Defibrillator Heart Surgery Prosthetic Cardiac Heart Valve Congenital Heart Disease Prev: Heart Infection Heart Transplant

Biosphosphonates	
Alendronate	Fosomax - Oral
Clodronate	Ostac, Bonefos IV and Oral
Etidronate	Didronel - IV and Oral
Ibandronate	Boniva - Oral
Pamidronate	Aredia - IV
Risedronate	Aectonel - Oral
Tiludronate	Skelid - Oral
Zoledronic-Acid	Zometa - IV

ALLERGIES OR BAD REACTION TO: (circle all that apply)

Aspirin	Nitrous Oxide	Latex Sensitivity
Codeine	Percodan	Fosmex Biophospytes
Demerol	Valium	Other:
Erythromycin	Penicillin	Other:
Tylenol or Tylenol #3	Sulfa Drugs	
Local Anesthetics	Tetracycline	

Have you ever taken prescription diet drugs alone or with other weight loss medication?

Fen-phen	YES	NO
Redux	YES	NO
Cortisone Medication	YES	NO
Bisphosphonates	YES	NO
Other:	_____	

INFECTIOUS DISEASES OR EXPOSURE TO SOMEONE WITH: (circle all that apply)

Hepatitis A (Infection)	Herpes I/II	Measles
Hepatitis B (Serum)	Venereal Disease	Mumps
Hepatitis C	AIDS, HIV	Chicken Pox
Rheumatic Fever	Epstein-Barr Virus	Tuberculosis
Scarlet Fever	Mononucleosis	

SURGERY: (circle all that apply)

Tonsils	Artificial Heart Valve	Joint Replacement
Adenoids	Pacemaker/Defibrillator	Other: _____
Cosmetic	Heart Surgery	_____

Do you have any CURRENT HEALTH PROBLEMS? YES NO

Are you under PRHYSICIAN'S CARE NOW? YES NO
For what? _____

Are you currently taking any medication? YES NO
If yes, what? _____

Have you been hospitalized recently? YES NO
If yes, for what? _____

Are there any Physical or Mental Handicaps? YES NO
If yes, what? _____

Current Physician's Names: _____
Address: _____
Phone: _____

Insurance Companies will only allow replacements for crows, bridges, & dentures after 5 or 10 years. How old are the crows, bridges or dentures?
[] 5 years/ [] 10 years/ _____

I hereby grant authority to:

Dr. Ali R. Egtesadi and/or associates to administer any treatment; or to administer such anesthesia; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I also acknowledge that I have read over and answered to the best of my knowledge all medical and dental history questions so that my dentist may be able to approach my dental care and treatment in a safe and patient-centered manner.

Signed* _____
(Patient or Legal Guardian)

Relationship: _____

Authorization must be signed by the patient, or by a guardian in the case of a minor or when the patient is physically or mentally incompetent.