BEAUTIFUL SMILES

PATIENT INFORMATION

Date_____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address_____

City_____

State_____ Zip _____

Date of Birth _____

Social Security # _____

Home Phone # _____

Cell Phone # _____

E-mail Address _____

****

Employer_____

Address_____

*Employer Work #*_____

****

Spouse's Name_____

Spouse's Employer_____

Spouse's Work #_____

****

Emergency Contact_____

Relationship_____

Phone #_____

****

How did you hear about our office?

_____

Do you know anyone who is in need of dental care?

_____

_____

DENTAL INSURANCE INFORMATION

Who is responsible for the account? Relationship to Patient

_____ _____

Subscriber's Name _____

Insurance Company_____ Group # _____

Date of Birth_____ Social Security # _____

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

Subscriber's Name _____

Insurance Company_____ Group # _____

Employer_____ Relationship to Patient _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependents, have insurance coverage with:

_____
(name of insurance company)

As I assign directly to ***Beautiful Smiles/Maryam Azadi, DMD*** all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by insurance.***
I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will allow ***Beautiful Smiles/Maryam Azadi, DMD,*** to use my healthcare information for the treatment and day to day healthcare operations of my treatment. ***This consent will be valid for one year from the effective date and will automatically renew for successive one year periods.***

_____
Signature of Patient, Parent or Guardian

_____
Please PRINT name of Patient, Parent or Guardian

_____ _____
Date Relationship to patient

DENTAL HISTORY

Reason for today's visit_____

Previous Dentist _____ Date of last visit_____ x-rays_____

How often do you brush your teeth? _____ How often do you floss?_____

Please mark "Yes" or "No" to indicate if you have had the following:

Bad Breath	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Pain or clicking around ear/TMD or TMJ	☐ Yes ☐ No
Food collection between teeth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Grinding teeth	☐ Yes ☐ No	Sensitivity to cold/hot	☐ Yes ☐ No
Gums swollen or tender	☐ Yes ☐ No	Sores or growths in your mouth	☐ Yes ☐ No

HEALTH HISTORY

Physician's Name_____ Date of last visit_____

Please mark "Yes" or "No" to indicate if you have had the following:

Have you ever taken any of the group of drugs collectively referred to as *phen-fen*"? ____Yes ____No
These include combinations Ionimin. Adipex, Fastin (brand names or phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Aids/HIV	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Liver Problems/ Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Artificial Joints/Joint Replacement	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Bleeding abnormally	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy/Radiation	☐ Yes ☐ No	Sleep Apnea	☐ Yes ☐ No
Cosmetic Surgery	☐ Yes ☐ No	Smoking Tobacco	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Tumor/growth on head/neck	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No		
Heart Surgery	☐ Yes ☐ No	Do you take birth control pills?	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No		
Heart Problems	☐ Yes ☐ No	*WOMEN*: Are you pregnant?	☐ Yes ☐ No
Hepatitis – type_____	☐ Yes ☐ No	Due Date _____	
High Blood Pressure	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No

Please list any additional medical conditions not listed above:

_____

ALLERGIES

Are you allergic to any of the following?

Aspirin	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Iodine	☐ Yes ☐ No
Penicillin	☐ Yes ☐ No
Sulfa Drugs (sulfite/sulfides)	☐ Yes ☐ No
Latex, Metals, Plastics	☐ Yes ☐ No
Local Anesthetics (Novocain)	☐ Yes ☐ No
Other: _____	☐ Yes ☐ No

MEDICATIONS

Please list all medications you are currently taking:

Medicine_____ Condition_____

Medicine_____ Condition_____

Medicine_____ Condition_____

Medicine_____ Condition_____

Medicine_____ Condition_____

*Pharmacy*_____ *Phone #*_____

*Dr. Signature*_____ *Date*_____