

# PATIENT INFORMATION

CHART # \_\_\_\_\_

### PATIENT

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Cell/Pager ( ) \_\_\_\_\_

E-mail \_\_\_\_\_

Social Security # \_\_\_\_\_

DL# \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

### RESPONSIBLE PARTY (If same as above, please skip)

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ DL# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

### EMPLOYMENT

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How Long? \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone ( ) \_\_\_\_\_ Ext. # \_\_\_\_\_

Verified By \_\_\_\_\_ Date \_\_\_\_\_

(Office use only)

### REFERENCES

Name \_\_\_\_\_  
Last First

Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Work Phone ( ) \_\_\_\_\_  
Last First

### PERSON TO CONTACT FOR EMERGENCY:

Last \_\_\_\_\_ First \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### GETTING TO KNOW YOU

Do you have family members who may need dental care?  
 If so, please list name & relationship (son, daughter, husband)

1: \_\_\_\_\_ 2: \_\_\_\_\_  
 3: \_\_\_\_\_ 4: \_\_\_\_\_

How did you hear about our office? (Circle one)

Family-Friend (400)	Insurance Plan (460)
ConfIDente (440)	Television (020)
Newspaper (470)	Radio (030)
Billboard (050)	Yellow Pages (120)
Flyer-Coupon (490)	Direct Mail-Postcard (480)
Office Sign (420)	Internet-Website (190)
Office Transfer (430)	

I want information in Spanish: YES \_\_\_\_\_ NO \_\_\_\_\_

### INSURANCE / DENTAL PLAN

Primary: Insurance PPO HMO (Circle one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

### INSURANCE / DENTAL PLAN

Secondary: Insurance PPO HMO (Circle one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

1. I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
2. By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party or Patient  
 (Parent if Patient is a Minor)

Date

# DOWNTOWN SMILE CENTER DR. RAFI DAVIDIAN

## GENERAL HEALTH INFORMATION

CHART # \_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_  
LAST FIRST

### DENTAL HISTORY

1. Reason for Visit / Main Concern? Check-Up  Cleaning  Toothache  Other \_\_\_\_\_
2. Are there other conditions of which we should be aware? YES  NO  If yes, please specify: \_\_\_\_\_
3. When did you last visit a dentist? \_\_\_\_\_
4. What treatment was performed? \_\_\_\_\_
5. Was the treatment completed? \_\_\_\_\_
6. When were dental x-rays taken? \_\_\_\_\_
7. Did you have a cleaning? YES  NO
8. Have you had gum (periodontal) treatment? YES  NO
9. Have you ever had prolonged bleeding after an extraction? YES  NO  If yes, please specify: \_\_\_\_\_
10. Have you had any problems with past dental treatment? YES  NO  If yes, please specify: \_\_\_\_\_
11. Do you grind your teeth, clench your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open?  
YES  NO  If yes, please specify: \_\_\_\_\_
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ?  
YES  NO  If yes, please specify: \_\_\_\_\_
13. Do your gums bleed easily? YES  NO
14. Do you feel you have bad breath? YES  NO
15. Are your teeth sensitive to hot or cold? YES  NO
16. Would you like your teeth whiter? YES  NO
17. Are you happy with your smile? YES  NO  If no, please explain: \_\_\_\_\_

### MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES  NO  If yes, please specify: \_\_\_\_\_ Dr. Name: \_\_\_\_\_  
Dr. Phone: ( ) \_\_\_\_\_
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? \_\_\_\_\_
3. Are you taking any medications at this time, including birth control? YES  NO  If yes, please specify: \_\_\_\_\_
4. (Women) Are you pregnant now? YES  NO  If yes, how many months? \_\_\_\_\_ Are you nursing? YES  NO
5. Are there any other health problems of which we should be advised? Please specify: \_\_\_\_\_
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"	Doctor Comments	Please check "YES" or "NO"	Doctor Comments
ARTIFICIAL HEART VALVE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEPATITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT REPLACEMENT YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LATEX ALLERGY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BISPHOSPHONATE THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BL. PRESSURE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SLEEP APNEA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TOBACCO YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
FAINTING YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK/SURGERY YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR/PROBLEMS YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

*To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.*

Patient's signature \_\_\_\_\_ (Parent if Patient is a Minor) \_\_\_\_\_ Date \_\_\_\_\_  
 Doctor Signature \_\_\_\_\_

### MEDICAL UPDATE:

1. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
2. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_
3. Patient's signature \_\_\_\_\_ Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_