PATIENT REGISTRATION AND HEALTH HISTORY

Amin Taba, DDS

Raising family dental care to new heights

TODAY'S DATE _____

WHO REFERRED YOU TO THIS OFFICE? _____

WHAT IS THE PURPOSE OF YOUR VISIT? _____

_____

GENERAL INFORMATION

Patient Name:

Dr., Mr., Mrs., Ms., Miss, Child _____ Birthdate _____
(CIRCLE ONE) FIRST MIDDLE LAST

Guardian's name if patient is a minor _____
FIRST MIDDLE LAST

Residence address _____
NUMBER STREET CITY STATE ZIP

Home phone _____ Cell phone _____ E-mail _____
AREA CODE AREA CODE

Occupation _____ Employer _____ No. of yrs. ___ S.S. # _____
(OR GUARDIAN IF PATIENT IS A MINOR)

Business address _____ Work phone _____
NUMBER STREET CITY AREA CODE

Name of spouse _____ S.S. # _____
(OR NAME OF PARENT OTHER THAN LISTED ABOVE)

Spouse's occupation _____ Employer _____ No. of yrs. _____
(OR OTHER PARENT'S OCCUPATION)

Spouse's business address _____ Spouse's work phone _____
(OR OTHER PARENT'S BUSINESS ADDRESS) NUMBER STREET CITY (OR OTHER PARENT'S WORK PHONE) AREA CODE

Children's names and ages _____

In case of emergency, list a local friend or relative who does not live with you:

Name _____ Relationship _____
FIRST MIDDLE LAST

Address _____ Phone _____
NUMBER STREET CITY AREA CODE

Please provide the name and address of another local friend or relative who does not live with you:

Name _____ Relationship _____
FIRST MIDDLE LAST

Address _____ Phone _____
NUMBER STREET CITY AREA CODE

INSURANCE INFORMATION – PLEASE COMPLETE IF YOU HAVE ANY TYPE OF DENTAL INSURANCE

Insurance subscriber's name _____ Subscriber's S.S. # _____

Name of insurance co. _____ Employer _____ Group no. _____ Birthdate _____
SUBSCRIBER'S

Is there **secondary dental insurance** that also covers this patient?

Insurance subscriber's name _____ Subscriber's S.S. # _____

Name of insurance co. _____ Employer _____ Group no. _____ Birthdate _____
SUBSCRIBER'S

GENERAL INFORMATION – PLEASE ANSWER EACH QUESTION

What is your main dental concern? _____

Date of last dental exam _____ Last cleaning _____

	Yes	No
Do you have any sore spots in your mouth?	❍	❍
Are you satisfied with the appearance of your teeth?	❍	❍
Have you even been treated for periodontal disease (gum disease)?	❍	❍
Do sweets, cold, heat or chewing cause you pain?	❍	❍
Have you ever had TMJ (jaw joint) clicking, popping, dislocation, pain?	❍	❍
Do you grind your teeth at night (bruxism)?	❍	❍
Have you been hospitalized in the last two years? If yes, for what? _____	❍	❍
Are you currently under the care of a physician? If yes, for what reason? _____	❍	❍
Are you taking medications regularly? If yes, for what reason? _____	❍	❍
Are you/have you ever taken Bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?	❍	❍
List **ALL** medications _____		
Have you ever had heart surgery or valve replacement, hip or joint replacement, or do you have a pacemaker?	❍	❍
Have you ever had a bad reaction to a medication?	❍	❍
Are you allergic to penicillin or other medications? If yes, which ones? _____	❍	❍
(Women) Are you now pregnant? If so, what month? _____	❍	❍

Circle any of the following that you have ever had:

heart attack	high blood pressure	radiation, chemotherapy	lung disease (asthma, COPD)
heart murmur	excessive bleeding	malignancies	AIDS/HIV/ARC
mitral valve prolapse	blood disorder, anemia	cancer	tuberculosis (TB)
rheumatic fever	stroke	abnormal reaction to anesthetic	VD (syphilis, herpes)
congenital heart lesions	diabetes	malignant hyperthermia	hepatitis, liver disease, jaundice
cardiac arrhythmia	ulcer/colitis	thyroid problem	kidney disease
artificial valve	glaucoma	sinus trouble	latex allergy

Please list any other condition or serious illness that could affect your health or dental treatment:

_____

Physician _____

Previous dentist _____

Additional comments (for Dr.'s use only) _____

_____

POLICY OF THE OFFICE

I *authorize* the release of my dental records from Dr. Amin Tabatabaian to other dentists or specialists involved in my dental care. I further authorize the release of my records from any individuals to Dr. Amin Tabatabaian.

I *authorize* insurance payments to be made directly to Dr. Amin Tabatabaian. I understand that I am financially responsible for any unpaid balance.

I *acknowledge* receipt of the Notice of Privacy Practices.

I *understand* that once an appointment has been made, this time has been reserved especially for me. I am aware that, should I not provide adequate 24-hour notice to change an appointment, I may be charged a fee.

I have read, understood and agree to the above _____

Signature of patient or guardian