



cosmetic+general dentistry

www.drkoopah.com

96 DAVIS RD., #6 • ORINDA, CA 94563 • (925) 254-4877

166 GEARY ST., 8TH FLOOR • SAN FRANCISCO, CA 94108 • (415) 421-2656

Patient Registration

1 Fill this box out if the appointment is for **YOU**

Name _____

Birthdate _____ Male Female

SS # _____

Address _____

City _____ Zip _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Fill this box out if the appointment is for **YOUR CHILD**

Date _____

Name _____

Address _____

City _____ Zip _____

Home Phone _____

Birthdate _____ Male Female

School _____ Grade _____

If you child's last name and/or address are not the same as yours, fill in the box to the left also.

2 Primary Carrier's Dental Insurance

Employee _____

Employer _____

Birthdate _____

Group # _____

Dental Ins. Carrier _____

Claims Address _____

City _____ State _____ Zip _____

Insurance ID or Subscriber ID # _____

Secondary Carrier's Dental Insurance

Employee _____

Employer _____

Birthdate _____

Group # _____

Dental Ins. Carrier _____

Claims Address _____

City _____ State _____ Zip _____

Insurance ID or Subscriber ID # _____

3 Employment and Other Information

Occupation _____

Employer _____

Business Address _____

City _____ State _____ Zip _____

Is another member of your family or relative a patient of ours?

Their Name _____

Whom may we thank for referring you to our practice? _____

4 Emergency Contact Information

In Case of Emergency:

Name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Relation to Patient _____

Continued on other side

Patient Medical History

Name of Medical Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. <i>Women Only:</i> Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following:		
			Local Anesthetics (e.g. Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
			Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
			Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
			Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
			Iodine	<input type="checkbox"/>	<input type="checkbox"/>
			Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
			Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____		
4. Have you ever taken Phen-Fen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>			
9. Do you have or have you had any of the following?					
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
			Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
			Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
			Stroke	<input type="checkbox"/>	<input type="checkbox"/>
			Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
			Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
			Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
			Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
			Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
			Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
			Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	14. Do you wear dentures or partials? If yes, date of placement _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	15. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>			
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			
8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>			

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____
Patient Signature (or parent/guardian if minor)

Doctor's Comments _____ _____ _____	
_____ _____ _____	_____ _____ _____
<i>Doctor's Signature</i>	<i>Date</i>