



Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

**Payment Method:**      \_\_\_ Cash      \_\_\_ Check      \_\_\_ Credit Card

**IN EVENT OF EMERGENCY**

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

**DENTAL INFORMATION**

Reason for today's visit: \_\_\_ Exam \_\_\_ Emergency \_\_\_ Consultation

Are you in pain? \_\_\_ No \_\_\_ Yes      How long? \_\_\_\_\_

Please indicate with a check any of the following problems:

\_\_\_ Discomfort, clicking or popping in jaw    \_\_\_ Lost/ Broken Filling(s)      \_\_\_ Stained Teeth

\_\_\_ Red, swollen or bleeding gums      \_\_\_ Teeth grinding      \_\_\_ Locking Jaw

\_\_\_ Sensitive tooth, teeth or gums      \_\_\_ Ringing in Ears      \_\_\_ Bad breath

\_\_\_ Blisters/Sores in or around the mouth    \_\_\_ Broken/Chipped tooth

\_\_\_ Other: \_\_\_\_\_

Do you require pre-medication? \_\_\_ Yes \_\_\_ No \_\_\_ Don't Know

Previous Dentist: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

Name

Phone #

Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_    Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_      Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use? \_\_\_ Soft \_\_\_ Medium \_\_\_ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

**Medical History**

Are you taking any of the following medications? \_\_\_ Nerve pills \_\_\_ Pain killers (including aspirin)

\_\_\_ Muscle relaxers    \_\_\_ Stimulants    \_\_\_ Blood Thinners    \_\_\_ Tranquilizers

\_\_\_ Insulin    \_\_\_ Other(s), please list: \_\_\_\_\_

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke      Y N Thyroid Problems      Y N Cancer/Tumors

Y N Heart Surg. /Pacemaker    Y N Cosmetic Surgery      Y N Kidney Problems

Y N Heart Murmur      Y N X-ray or Cobalt Treatment    Y N Shingles

Y N Liver Problems      Y N Hepatitis      Y N Chemotherapy

Y N Rheumatic Fever      Y N Asthma      Y N HIV+/AIDS/ARC

Y N Mitral Valve Prolapse    Y N Sinus Problems      Y N Difficulty Breathing

Y N Arthritis/ Rheumatism    Y N Respiratory Problems    Y/N Artificial Valves

Y N Stomach Problems/ Ulcers    Y N Artificial Bones/Joints    Y N Diabetes/Hypoglycemia

Y N Heart Disease      Y N Psychiatric Problems    Y N Emphysema

Y N Leukemia      Y N Congenital Heart Defect    Y N Venereal Disease

Y N Fainting/Seizures/Epilepsy    Y N Anemia      Y N Chest Pains

Y N Alcohol/Drug Abuse    Y N High/Low Blood Pressure    Y N Severe/Frequent Headaches

Y N Scarlet Fever      Y N Tuberculosis TB      Y N Frequent Neck Pain

Y N Bleeding Problems    Y N Nervousness      Y N Jaw Problems TMJ/TMD

Y N Back Problems      Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

\_\_\_\_\_

Are you allergic to any of the following?  Latex  Penicillin/Amoxicillin  Aspirin  
 Tetracycline  Dental Anesthetics  Others: \_\_\_\_\_  
Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_  
Please rate your general health from 1-10: \_\_\_\_\_

Have you ever taken the drug Phen-fen and or Redux?  Yes  No

**For women:** Are you taking Birth Control pills?  Yes  No

Are you pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  No  Yes

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit. If account is not paid within 30 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the Dr. Javaheri and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_ Adult Patient \_\_\_\_ Parent or Guardian \_\_\_\_ Spouse