Dr. Kian Nabavizadeh
797 S. Tracy Blvd. Tracy CA, 95376
(209) 839-8594

Today's Date: _____/_____/_____

PATIENT INFORMATION

Name: _____
Last First MI
What You Prefer To Be Called: _____ __ Male __ Female

Birth date: _____/_____/_____ Age: _____ SS#: _____
Mailing Address: _____
_____
City State Zip
Home Phone: (_____) _____Work Phone:(_____)_____
Cell Phone: (_____)_____Email:_____
Referred By: _____Occupation:_____

INSURANCE INFORMATION

Primary Dental Insurance

Company Name: _____
Address: _____
_____
City State Zip
Phone #: (____) _____
Insured's SS#: _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____
Relation: _____ Date of Birth: _____/_____/_____
Insured's Employer: _____

ACCOUNT INFORMATION

Person ultimately responsible for account

Name: _____
Relation: _____
Billing Address: _____
_____
City State Zip
SS #:_____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/popping in jaw
— Lost/ Broken Filling(s)
— Stained Teeth
— Red, swollen or bleeding gums
— Teeth grinding
— Sensitive tooth, teeth or gums
— Locking Jaw
— 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-rat/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? ___Yes___No
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?___ Yes ___ No How far along? _____ Are you nursing? ____ Yes ___ No

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- 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.
- I authorize Dr. Nabavizadeh 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