

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? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Have you even been treated for periodontal disease (gum disease)? Yes No

Do sweets, cold, heat or chewing cause you pain? Yes No

Have you ever had TMJ (jaw joint) clicking, popping, dislocation, pain? Yes No

Do you grind your teeth at night (bruxism)? Yes No

Have you been hospitalized in the last two years? If yes, for what? _____ Yes No

Are you currently under the care of a physician? If yes, for what reason? _____ Yes No

Are you taking medications regularly? If yes, for what reason? _____ Yes No

Are you/have you ever taken Bisphosphonates (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? Yes No

List **ALL** medications _____

Have you ever had heart surgery or valve replacement, hip or joint replacement, or do you have a pacemaker? Yes No

Have you ever had a bad reaction to a medication? Yes No

Are you allergic to penicillin or other medications? If yes, which ones? _____ Yes No

(Women) Are you now pregnant? If so, what month? _____ Yes No

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