PATIENT INFORMATION

Today's Date | Patient Name (Circle/highlight one) Mr. Mrs. Ms. Miss Dr. | (Age) | (Birth date)

Residence Address: (Street) (City) (State) (Zip)

Mobile Phone | Secondary Phone (Circle/highlight one) Work Home | Email

Social Security Number | Driver's License No.

In case of emergency (Relationship) | Phone number | Email

Name /city/number of previous dentist

Occupation | Employer (if applicable)

Business Address: (Street) (City) (State) (Zip)

DENTAL INSURANCE:

IF you are insured by a spouse/parent:

Spouse/Parent (Circle One) Name | (Birth date) | (Soc. Sec. No or Ins. ID)

Their Employer | (Work Phone)

PATIENT'S Insurance (If applicable)

(Insurance Company name)

(Street/P.O. Box)

(City) (State) (Zip)

(Group #) (Phone)

SPOUSE'S/PARENT'S Insurance (If applicable)

(Insurance Company name)

(Street/P.O. Box)

(City) (State) (Zip)

(Group #) (Phone)

500 Sutter St., Suite 405 + San Francisco, CA 94102

Ph. 415-399-9595 missirliandds@gmail.com
Fax 415-399-9598 missirliandds.com

MDA
Missirlian Dental Associates

DENTAL HISTORY

Circle or highlight the appropriate answers. Use the line provided to explain. If more room is needed, please go to the end of the form. If you do not have any teeth, fill in what you can. Patients with removable full or partial dentures, please fill in the "Denture History" as well.

When was your last dental visit/cleaning? >6 mo. 1-2 yrs. 3+ yrs._____

When was the last full series of x-rays taken? 1 yr. 2 yrs. 3+ yrs_____

Yes No Do you have an immediate dental concern?_____

Yes No Any strong fears or dislikes regarding dental treatment? _____

Yes No Do you require antibiotics (pre-medication) prior to dental treatment? _____

Yes No Have you had a serious problem associated with dentistry?_____

Yes No Are you satisfied with the quality of dental care received?_____

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

Yes No Are you able to chew your food comfortably?_____

Yes No Do you worry very much about your teeth? _____

Yes No Are you interested in keeping your teeth? _____

Yes No Are your teeth sensitive? To Heat cold sweets pressure_____

Yes No Are you satisfied with the color of your teeth?_____

Yes No Are you interested in bleaching your teeth? _____

Yes No Are you aware of a bad odor or taste in your mouth?_____

Yes No Have you lost any teeth? _____

Yes No Do your teeth feel loose? _____

Yes No Have your teeth ever moved from their normal position? _____

Yes No Do your gums bleed when you brush? _____

Yes No Have any teeth ever fractured? _____

Yes No Have you had frequent sores in your mouth? _____

Yes No Have you ever been treated for gum disease? _____

Yes No Have you ever had orthodontics (braces)? (When/Why?) _____

Yes No Have you ever had your teeth equilibrated (adjusted)? _____

Yes No Have you ever worn an occlusal splint? (Why?) _____

Yes No Have you any oral habits? (gum chewing, nail biting, other)_____

Yes No Do you grind or clench your teeth? Day/Night _____

Yes No Do you have difficulty opening or closing your mouth? (Explain) _____

Yes No Are you aware of any pain or clicking in your jaw joints? (Explain) _____

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Yes No Have you had injuries to your mouth or jaws? _____

Yes No Do you get headaches frequently? _____

Yes No Do you play a musical instrument that uses a mouthpiece? _____

Yes No Do you suffer from excessive snoring or any sleep disorder? _____

Yes No Have you had a sleep study? If yes, do you wear a CPAP? Yes No _____

Yes No Do get cold sores easily &/or have you ever had oral herpes? _____

Yes No Have you had bulimia or frequent vomiting? _____

Yes No Have you taken the diet aid known as Fen-Phen? _____

Yes No Are you allergic to latex or rubber products? _____

Yes No Does your skin change color after wearing certain jewelry? _____

Yes No Have you had a problem breaking or losing fillings? _____

Yes No Have you had your teeth been cleaned in the past five years? ~ How many times?_____

Yes No Has a dentist/hygienist given you oral hygiene lessons? _____

Yes No Do you floss? _____ How often? _____Type of floss?_____

Yes No Have you been/are you on a home fluoride program? _____

Yes No Do you use mouthwash? If so, how often? What type? _____

Yes No Do you use breath mints or hard candies containing sugar? _____

Yes No Do you consume food or drinks high in sugar?_____

Yes No Do you usually have many cavities? _____

Yes No Is your mouth often dry? _____

Yes No Do you need to have acid reflux or need to take antacids? _____

How many times do you brush your teeth? ___/day. When?_____For how long? _____

What type of brush do you use? Soft Medium Hard Electric _____

Which toothpaste do you use? _____

Any other cleaning techniques you use?_____

Yes No Do the bristles on your brush bend out of shape? _____

Yes No Do you scrape/brush your tongue? _____

Yes No **If** you wear a bridge, do you clean under it? Daily Sometimes Never _____

What is your own general impression of your teeth? _____

_____

_____

Anything else? _____

_____

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DENTURE HISTORY

Fill out ONLY if you wear REMOVABLE DENTURES OR PARTIALS

How long have you been wearing dentures? _____

How long have you worn current dentures? Upper _____ Lower _____

How many sets have been made for you? Upper _____ Lower _____

Yes No Were your present dentures placed the day of extractions? _____

Yes No Are you having a problem with your dentures? _____

Yes No If they are successful, how so? _____

Yes No Are you satisfied with the appearance of your dentures _____

Yes No Are you able to eat satisfactorily? _____

Yes No Are you able to speak satisfactorily? _____

Yes No Do you have any gagging or saliva problems with your dentures? _____

Yes No Are there foods you cannot eat with your dentures? _____

Yes No Do you use adhesives or home-liners? _____

Yes No Have your dentures ever been relined? _____

Yes No Are your dentures in need of frequent repairs? _____

Yes No Have you ever had fungus under your denture? _____

Yes No Have you ever developed sores at the corners of your mouth? _____

Yes No Do you keep your dentures out at night? _____

Yes No How do you clean your dentures? _____

Yes No Do you massage your gums? _____

Yes No Do you have problems with soreness or sore spots? _____

Yes No Does food get under your dentures? _____

Yes No Do you have a spare set of dentures? _____

Yes No Do you expect dentures to function as well as your own teeth did? _____

Yes No Do you expect dentures to eliminate wrinkles on your face? _____

Yes No Do you think dentures should fit tightly? _____

Yes No Do you think upper and lower dentures should fit equally well? _____

Yes No Are your present dentures loose? Upper _____ Lower _____

Yes No Have you ever had surgery on your ridges (gums or bone?) _____

Yes No Do you have or have you ever had implants _____

Yes No Have implants ever been suggested? _____

How long do you think a set of dentures should last? _____

Any other information important to understanding your denture history? Do you have any expectations from treatment? _____

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HEALTH HISTORY

Circle or highlight appropriate answer. Use the line provided to explain. If you need more room, please go to the end of the form. If you do not have any teeth, fill in what you can.

Yes No Do you have any general health problems? _____

Yes No Has there been a change in your health within the last year? _____

Yes No Have you been hospitalized or had a serious illness in the last three years? _____

Yes No Are you being treated by a physician now? For what? _____

Physician's Name: _____

Phone Number: _____ City (address if known)_____

Yes No Have you had problems with prior dental treatment? _____

Yes No Are you in pain now? _____

HAVE YOU EVER HAD OR EXPERIENCED:

Yes	No	Chest pain (angina)?	Yes	No	Dizziness?
Yes	No	Swollen ankles?	Yes	No	Ringing in Ears?
Yes	No	Shortness of Breath	Yes	No	Headaches?
Yes	No	Weight loss/fever/night sweats?	Yes	No	Fainting spells?
Yes	No	Persistent cough?	Yes	No	Blurred vision?
Yes	No	Bleeding/Bruising easily?	Yes	No	Seizures?
Yes	No	Sinus Problems?	Yes	No	Excessive thirst?
Yes	No	Difficulty swallowing?	Yes	No	Frequent urination?
Yes	No	Diarrhea/constipation/blood in stools?	Yes	No	Dry mouth?
Yes	No	Frequent vomiting, nausea?	Yes	No	Jaundice?
Yes	No	Difficulty urinating/blood in urine?	Yes	No	Joint pain/stiffness?
Yes	No	Heart Disease?	Yes	No	HIV or AIDS?
Yes	No	Heart attack/heart defects?	Yes	No	Tumors/cancer?
Yes	No	Heart Murmur?	Yes	No	Arthritis/rheumatism?
Yes	No	Rheumatic fever?	Yes	No	Eye disease?
Yes	No	Stroke/hardening of arteries?	Yes	No	Skin disease
Yes	No	High blood pressure?	Yes	No	Anemia?
Yes	No	Asthma/TB/emphysema/lung disease?	Yes	No	STD? (Ex. Syphilis)
Yes	No	Hepatitis (type ____)/liver disease?	Yes	No	Herpes?
Yes	No	Stomach problems/ulcers?	Yes	No	Kidney/bladder disease
Yes	No	Family history of diabetes/heart/tumor?	Yes	No	Thyroid/adrenal disease
Yes	No	Psychiatric care?	Yes	No	Hospitalization?
Yes	No	Radiation treatments?	Yes	No	Blood Transfusions?
Yes	No	Chemotherapy?	Yes	No	Surgeries?
Yes	No	Prosthetic heart valve?	Yes	No	Pacemaker?
Yes	No	Allergies to drugs/latex? _____	Yes	No	Diabetes?

ARE YOU TAKING:

Yes No Marijuana? _____ Yes No Tobacco in any form? _____

Yes No Other recreational drugs?_____ Yes No Alcohol? Type/Quantity? _____

Yes No Medications? List all OTC, prescription, herbal: _____

Yes No Are you/could you be pregnant/nursing? Yes No Taking birth control pills?

Yes No Do you have or have you had any other diseases/medical condition NOT listed above?

Please list: _____

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Cell Phone and Email Consent:

❑ *I consent to the dental practice using my cell phone to (choose one or both)* ❑ *call and* ❑ *text*

❑ *I consent to the dental practice using my email for contact regarding appointments and to contact me regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.*

Acknowledgement of Receipt of
NOTICE OF PRIVACY PRACTICES* and DENTAL FACT MATERIAL SHEET
(*You May Refuse to Sign This Acknowledgement)

I. NOTICE OF PRIVACY:

I acknowledge I have received a copy of the **Notice of Privacy** from Missirlian Dental Associates.

_____

Patient Signature

We, the office of Missirlian Dental Associates, attempted to obtain written acknowledgement of receipt of our Notice of Privacy, but it could not be obtained because:

A. ❑Individual refused to sign B. ❑Communication barriers prohibited obtaining the acknowledgement

C. ❑An emergency situation prevented us from obtaining acknowledgment D. ❑Other (Specify below)

_____

_____

Signature of witness from the office of Donald Missirlian, DDS and Associates

II. DENTAL FACT MATERIAL SHEET *:

I acknowledge I have received a copy of the **Dental Fact Material Sheet (DFMS)** from Missirlian Dental Associates.

_____

Patient's Signature (***The Notice of Privacy and DFMS sheets will be given at time of appointment)**

APPOINTMENTS: Please help us maintain the operation of our office on sound principles so that we may assure you and other patients of uninterrupted treatment. Remember that once you have made an appointment, this time is reserved for you; therefore, at least 48-hour notice must be given if cancellation is absolutely necessary. Otherwise a serious delay in treatment may develop, and a fee (up to $300/hr.) may be charged.

FINANCIAL POLICY: This statement is to inform you of our financial policy. We are committed to providing you with excellent dental care. Our financial policy is intended to facilitate service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of insurance coverage. We must emphasize that as your dental provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and/or your employer and your insurance company. Our office is not a party of that contract. As a courtesy to you, we will help process all your insurance claims. Payment is due at time of service provided. Our office accepts cash, personal checks, Debit cards, Visa, and MasterCard, all with proper photo ID. Returned checks for insufficient funds are subject to a $39.00 fee; balances over 60 days may be subject to interest. Further delays in payment may result in collection fees. If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience with your dental care.

_____

Patient's Signature Date

_____

Reviewed Date

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