



New Patient Information

Dr. Aziza Askari, FAGD
Phone: 248-474-6434
www.ComfortDentalSpa.com

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Today's date (MM/DD/YYYY)
First name Middle initial Last name
I prefer to be called (nickname, etc.) Male Female
Address City State ZIP
Date of birth Social Security No.
Home phone Work phone Cell phone
Primary contact number (please check one) Home Work Cell Best time and day to call
Fax E-mail Driver's license no.
Employer Occupation
Spouse's name Spouse's employer
Whom may we thank for referring you?
If the patient is a child
School School phone Grade

Dental History

Reason for today's visit
Are you currently in pain? Yes No
If so, please describe:
Do you have any dental problems now? Yes No
If so, please describe:
Have you ever had trouble with a previous dental treatment? Yes No
If so, please describe:
Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)
Date of last dental exam Date of last cleaning Date of last full mouth X-rays
Procedure(s) done at last dental visit
Previous dentist's name
City State Phone
Why are you changing dentists?
How often do you have dental examinations? How often do you brush your teeth?
How often do you floss? What type of bristles do you use? Hard Medium Soft
What other dental aids do you use? (Electric toothbrush, toothpick, etc.)

Do you require antibiotics before dental treatment? Yes No
Do you have frequent headaches? Yes No
Do your gums ever bleed? Yes No
Do you clench or grind your teeth? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Are your teeth sensitive to heat/cold? Yes No
Do you bite your lips or cheeks frequently? Yes No
Do you still have your wisdom teeth? Yes No

Have you ever had:

Periodontal disease/gum treatment Yes No
Discomfort in your jaw joint (TMJ/TMD) Yes No
Orthodontics treatment Yes No
Your teeth ground or bite adjusted Yes No
Oral surgery Yes No
Serious injury to the mouth or head Yes No
A bite plate or mouth guard Yes No

If yes to any of the previous questions, please describe

Is there anything else about your past dental treatment(s) that you would like us to know?



Medical History
Patient Name \_\_\_\_\_

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Have you been hospitalized or under the care of a medical doctor during the past 2 years?
If yes, for what? \_\_\_\_\_
Hospital or Physician's name \_\_\_\_\_ Phone \_\_\_\_\_
Hospital or Physician's City \_\_\_\_\_ State \_\_\_\_\_

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines)
If yes, please explain \_\_\_\_\_

Have you been to the doctor to check for heart problems?
If so, what are the problems? \_\_\_\_\_

Do you use tobacco? Do you use alcohol or any other controlled substance?
Women only:
Are you pregnant or think you may be pregnant?
Are you taking birth control pills?
Are you nursing?

- Indicate which of the following you have had or have at present:
AIDS/HIV, Alcohol/Drug Abuse, Allergies or Hives, Anemia, Arthritis/Rheumatism, Artificial Heart Valve, Artificial Bones/Joints, Asthma, Blood Disease, Blood Transfusion, Bruise Easily, Cancer/Chemotherapy, Chest Pain, Cold Sores/Herpes, Colitis, Cortisone Medicine, Diabetes, Diet (Special/Restricted), Difficulty Breathing, Emphysema, Epilepsy or Seizures, Fainting or Dizzy Spells, Frequent Headaches, Glaucoma, Heart (Surgery, Disease, Attack), Heart Pacemaker, Heart Murmur, Hemophilia/Abnormal Bleeding, Hepatitis A B C (circle), High or Low Blood Pressure, Hospitalized for Any Reason, Jaundice, Kidney Trouble, Liver Disease, Lupus, Mitral Valve Prolapse, Nervousness/Anxiety, Neurological Disorders, Psychiatric/Psychological Care, Radiation Therapy, Rheumatic/Scarlet Fever, Shingles/Chicken Pox, Sickle Cell Disease/Traits, Sinus Trouble, Snoring/Sleep Apnea, Stomach Problems/ Ulcers, Stroke, Swollen Ankles, Thyroid Problems, Tuberculosis (TB), Tumors, Contact Lenses, Venereal Disease/STD

Please list any serious medical condition(s) that you have ever had not listed above:
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Please list any medication/products that you might be allergic to:
\_\_\_\_\_
\_\_\_\_\_

Are you taking any herbal supplements or vitamins? If so please list:
\_\_\_\_\_
\_\_\_\_\_

Patient signature \_\_\_\_\_



Primary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_
Address (Street, City, State, ZIP) \_\_\_\_\_
Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_
Date of birth \_\_\_\_\_ Insured's Social Security No. \_\_\_\_\_
Insured's employer name \_\_\_\_\_ Is insured a patient in our practice? [ ] Yes [ ] No

Secondary Carrier

Insurance co. name \_\_\_\_\_ Insurance co. phone \_\_\_\_\_
Address (Street, City, State, ZIP) \_\_\_\_\_
Group no. (Plan or Policy no.) \_\_\_\_\_ Insured's I.D. no. \_\_\_\_\_
Insured's name \_\_\_\_\_ Relationship to patient \_\_\_\_\_
Date of birth \_\_\_\_\_ Insured's Social Security no. \_\_\_\_\_
Insured's employer name \_\_\_\_\_ Is insured a patient in our practice? [ ] Yes [ ] No
Medical Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_ Tel. Number \_\_\_\_\_
Medical Insurance Address \_\_\_\_\_ Group Number & Subscriber name \_\_\_\_\_

Preferred payment method: [ ] Cash [ ] Credit Card [ ] Check

Visa/MC/AMEX no. \_\_\_\_\_ Exp. date \_\_\_\_\_

If patient is a minor or has special needs, name of parent or legal guardian and relationship \_\_\_\_\_

Is this parent or legal guardian currently a patient in our office? [ ] Yes [ ] No

Payment is due in full at the time of treatment
(Unless prior arrangements have been approved)

I understand that the payment is due at the time of service. Comfort Dental Spa shall provide the complimentary filing of my benefit claims. The information is accurate and true to the best of my knowledge. . Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication. I understand that I am responsible to pay for services rendered, incurring reasonable attorney fees and costs of collection in the event of default. I authorize Comfort Dental Spa to charge any unpaid balance after my Insurance has paid to my credit card on file. There will be a finance charge of \$ 75.00 for all balances past 31 days.

Appointment Policy I understand that my appointments are reserved according to my convenience and there maybe a \$100 charge for any missed appointments or cancellations within 48 hours of the appointment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Person to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ Cell phone \_\_\_\_\_
Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Acknowledgement of Receipt of Notice of Privacy Practices

I \_\_\_\_\_, have read and/or received a copy of the Comfort Dental Spa's Notice of Privacy Practices.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(if under 18 years of age)

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date \_\_\_\_\_ Initials \_\_\_\_\_

We attempted to obtain a written acknowledgement of the receipt of our Notice of Privacy Practices; acknowledgement could not be obtained because:

\_\_\_\_ Individual refused to sign \_\_\_\_ Communication Barriers prohibited obtaining the acknowledgement

\_\_\_\_ An emergency situation prevented us from obtaining the acknowledgement \_\_\_\_ Other (please specify) \_\_\_\_\_





Health History Update  
Patient Name \_\_\_\_\_

Dr. Aziza Askari, FAGD  
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Today's date \_\_\_\_\_  
(MM/DD/YYYY)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Home phone  
( ) - \_\_\_\_\_ Work ( ) - \_\_\_\_\_ Cell ( ) - \_\_\_\_\_  
E-mail \_\_\_\_\_ Fax ( ) - \_\_\_\_\_

Anything else we should know? \_\_\_\_\_  
\_\_\_\_\_

Health changes since last visit: \_\_\_\_\_ Date health change occurred \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Current medications  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last physical exam \_\_\_\_\_ Any allergies? \_\_\_\_\_

Patient signature \_\_\_\_\_ Staff initials \_\_\_\_\_ Date \_\_\_\_\_

Health changes since last visit: \_\_\_\_\_ Date health change occurred \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_ Physician's phone \_\_\_\_\_

Current medications  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last physical exam \_\_\_\_\_ Any allergies? \_\_\_\_\_

Patient signature \_\_\_\_\_ Staff initials \_\_\_\_\_ Date \_\_\_\_\_