Lisa B. Kederian DDS
New Patient Form

Patient Information:

Last Name:_____ Date: _____/_____/_____

First Name:_____ Nickname:_____

Middle Inital:_____ Sex: [ ] Male [ ] Female Salutation: Mr./Mrs./Ms./Dr. (please circle)

Home Address:_____

City:_____ State:_____ Zip:_____

Soc. Sec: _____ D.O.B:_____

Home Phone: _____ Work Phone:_____

Cell:_____Email: _____

How should we contact you:_____

Who may we thank for referring you:_____

Insurance Information:

Carrier Name:_____ Group Number:_____

Subscriber:_____ Soc. Sec.:_____

Subs. DOB:_____

Relationship:_____Person responsible for this account:_____

Employer:_____

Emergency Contact Information:

Name:_____ Relationship:_____

Address:_____ Daytime Phone:_____

Previous Dentist:

Name :_____ Phone:_____

Address:_____ City:_____ State:_____

Date of last visit:_____

Current Medical Doctor:

Name:_____ Phone:_____

Address:_____ City:_____ State:_____

Date of last visit:_____

Signature:_____ Date:_____/_____/_____

(Self, Parent,Guardian)

***Please be advised we request a 24 hour notice for all cancellations to avoid a cancellation Fee of $50**

11500 Olympic Blvd. Ste. 604 Los Angeles, CA 90064.

Reason for today's visit:_____

Please answer all the questions by checking yes or no.

You responses will be held strictly confidential and will only be used to help assess your medical condition. If you have any hesitations, please express your concerns with a member of our team.

Do you have, or did you ever have, any of the following:

Cardiovascular:

Yes	No	
[ ]	[ ]	High blood pressure
[ ]	[ ]	Heart disease
[ ]	[ ]	Heart Murmur
[ ]	[ ]	Rheumatic fever
[ ]	[ ]	Use of Phen-Fen
[ ]	[ ]	Pace Maker
[ ]	[ ]	Vascular graft
[ ]	[ ]	Heart valve replacement
[ ]	[ ]	Heart attack
[ ]	[ ]	Heart surgery
[ ]	[ ]	Congestive heart failure
[ ]	[ ]	Angina (chest pain)
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Stroke
[ ]	[ ]	Increased cholesterol

Endocrine/Hematologic/ Oncologic/Immune:

Yes	No	
[ ]	[ ]	Frequent hunger
[ ]	[ ]	Frequent thirst
[ ]	[ ]	Diabetes
[ ]	[ ]	Thyroid disease
[ ]	[ ]	Hemophilia
[ ]	[ ]	Sickle cell disease
[ ]	[ ]	Bleeding tendency
[ ]	[ ]	Anemia
[ ]	[ ]	Cancer
[ ]	[ ]	Radiation therapy
[ ]	[ ]	Chemo therapy
[ ]	[ ]	HIV infection/AIDS
[ ]	[ ]	Organ transplant
[ ]	[ ]	Blood transfusion

Do you have, or did you ever have, any of the following:

Musculo-skeletal/CNS/Developmental:

Yes	No	
[ ]	[ ]	Chronic jaw and facial pain
[ ]	[ ]	Chronic headache pain
[ ]	[ ]	Chronic neck pain
[ ]	[ ]	Popping or clicking in your jaw
[ ]	[ ]	Joint replacement
[ ]	[ ]	Osteoarthritis
[ ]	[ ]	Rheumatoid arthritis
[ ]	[ ]	Spinal cord injury
[ ]	[ ]	Seizures
[ ]	[ ]	Dizziness
[ ]	[ ]	Weakness
[ ]	[ ]	Multiple Sclerosis
[ ]	[ ]	Cerebral palsy
[ ]	[ ]	Mental Retardation
[ ]	[ ]	Dementia/Alzheimer's
[ ]	[ ]	Fainting spells
[ ]	[ ]	Visual Impairment
[ ]	[ ]	Glaucoma
[ ]	[ ]	Hearing impairment

Gastro-Intestinal/Genito-Urinary:

Yes	No	
[ ]	[ ]	Hepatitis (A,B,C, or other?)
[ ]	[ ]	Kidney dialysis
[ ]	[ ]	Ulcers
[ ]	[ ]	Sexually Transmitted disease
[ ]	[ ]	Denied permission to give blood

Psychological:

Yes	No	
[ ]	[ ]	Anxiety/Nervousness
[ ]	[ ]	Depression
[ ]	[ ]	Mental health treatment
[ ]	[ ]	Insomnia

Do you have, or did you ever have, any of the following:

Respiratory:

Yes No
[ ] [ ] Asthma
[ ] [ ] Chronic Sinus Problems
[ ] [ ] Night Sweats
[ ] [ ] Emphysema
[ ] [ ] Tuberculosis
Other:_____

Social:

Yes No
[ ] [ ] Do you use tobacco products?
If so, how much?_____
[ ] [ ] Do you drink alcohol?
If so, how much?_____
[ ] [ ] Do you use recreation drugs?

Do you have any medical conditions not already mentioned?

_____
_____

History of hospitalizations/ surgical Procedures:

_____
_____

Females Only:

Yes No
[ ] [ ] Are you pregnant now?
If so, #_____ months
[ ] [ ] Do you take birth control pills?
[ ] [ ] Are you breast feeding now?

Other:

Yes No
[ ] [ ] Does the amount of saliva in your mouth seems to be too little?
[ ] [ ] Does your mouth feel dry when Eating a meal?

Medication Allergy or Intolerance:

Yes No
[ ] [ ] Penicillin
[ ] [ ] Dental anesthetic ("Novocain")
[ ] [ ] Aspirin
[ ] [ ] Codeine
[ ] [ ] Latex products
[ ] [ ] Iodine
Other:_____

Medications:

Yes No
[ ] [ ] Are you taking any prescriptions medicines, any over-the-counter items or any herbal medicines now?

If so, please list them and the doses you use:

_____
_____
_____
_____
_____
_____
_____

Do you or have you ever used biphosphate medication (i.e. Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, zometa and Bonefos) to prevent or treat osteoporosis or as part of a cancer treatment?

Yes No
[ ] [ ]

If yes, what type of Biphosphonate?

_____

How long have you been or were you taking the Biphosphonate?_____

To the best of my knowledge, all of the proceeding answers are true. If I have any changes in my health status, or any change in my medications, I will inform my dental health care provider at my next appointment.

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_____ _____
Signature (Self, Parent, Guardian) Date

_____ _____
Doctor's Signature Date