

Lisa B. Kederian DDS  
New Patient Form

**Patient Information:**

Last Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
Middle Initial: \_\_\_\_\_ 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. 326 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 seem to be too little?
- Does your mouth feel dry when Eating a meal?

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)

\_\_\_\_\_  
Doctor's Signature

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?\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date