**<u>Dr. Dino Javaheri</u>**
400 El Cerro Blvd. Suite 101, Danville CA, 94526
(925) 837-5889

Today's Date: ______/_______/________

**PATIENT NAME:** ____________________________________________________________
Last First MI
What You Prefer To Be Called: ______________________________ __ Male __ Female
Birth date: ________/_______/_______ Age: ______ SS#: ____________________________________
Mailing Address: ______________________________________________________________________
______________________________________________________________________________________
City State Zip
Home Phone#: (_______) ____________________Work Phone#: (_______) ______________________
Cell Phone#: (_______) ________________________Email:____________________________________
Referred By: _____________________________________ Occupation: ___________________________

## INSURANCE INFORMATION

**<u>Primary Dental Insurance</u>**
Company Name: ________________________________________________________________________
Address: _____________________________________________________________________________
______________________________________________________________________________________
City State Zip
Phone #: (____) ________________________________________________________________________
***Insured's SS#:*** ______________________________________________________________________
Group # (Plan, Local or Policy #): _________________________________________________________
***Insured's Name***: _____________________________________________________________________
Relation: _______________________________ Date of Birth: ______/_______/___________________
***Insured's Employer***: ___________________________________________________________________

**<u>Secondary Dental Insurance</u>**
Company Name: ________________________________________________________________________
Address: _____________________________________________________________________________
______________________________________________________________________________________
City State Zip
Phone #: (_____) _______________________________________________________________________
***Insured's SS#:*** ______________________________________________________________________
Group # (Plan, Local or Policy #): _________________________________________________________
***Insured's Name***: _____________________________________________________________________
Relation: ________________________________ Date of Birth: _____/______/______________________
***Insured's Employer***: ___________________________________________________________________
_____ Initials I hereby authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

## ACCOUNT INFORMATION

**Person ultimately responsible for account**
Name: _________________________________________________________________________________
Relation: ______________________________________________________________________________
Billing Address: ________________________________________________________________________

___________________________________________________________________________
City State Zip
SS #: _____________________________________________________________________

Drivers License #: ________________________________________________

Work Phone #: (_____) ____________________________________________

**Payment Method:** ____ Cash _________ Check ______Credit Card

## IN EVENT OF EMERGENCY

Whom should we contact? ___________________________________________
Relation: __________________________________________________________
Home Phone #: (_____) ______________________________________________
Work Phone #: (______) ______________________________________________
Cell Phone #: (______) ______________________________________________
Who is your Medical Doctor? __________________________________________
Medical Doctor's Phone #: (_____) _____________________________________

## DENTAL INFORMATION

Reason for today's visit: ___ Exam___ Emergency ___ Consultation
Are you in pain? ____ No ____ Yes How long? ______________________
Please indicate with a check any of the following problems:
___ Discomfort, clicking or popping in jaw ___ Lost/ Broken Filling(s) __ Stained Teeth
___ Red, swollen or bleeding gums ___ Teeth grinding __ Locking Jaw
___ Sensitive tooth, teeth or gums ___ Ringing in Ears __ Bad breath
___ Blisters/Sores in or around the mouth ___ Broken/Chipped tooth
___ Other: _____________________________________________________
Do you require pre-medication? ___ Yes ___ No ___ Don't Know
Previous Dentist: ________________________________ (____) __________
Name Phone #
Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/__________
Times a day you brush? __________ Times a week you floss? _______________
What type of tooth brush bristles do you use? ___ Soft ___ Medium ___ Hard
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

## Medical History

Are you taking any of the following medications? ___ Nerve pills ___ Pain killers (including aspirin)
___ Muscle relaxers ___ Stimulants ___ Blood Thinners ___ Tranquilizers
___ Insulin ___ Other(s), please list: _________________________________
Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack/ Stroke
Y N Heart Surg. /Pacemaker
Y N Heart Murmur
Y N Liver Problems
Y N Rheumatic Fever
Y N Mitral Valve Prolapse
Y N Arthritis/ Rheumatism
Y N Stomach Problems/ Ulcers
Y N Heart Disease
Y N Leukemia
Y N Fainting/Seizures/Epilepsy
Y N Alcohol/Drug Abuse
Y N Scarlet Fever
Y N Bleeding Problems
Y N Back Problems
Y N Thyroid Problems
Y N Cosmetic Surgery
Y N X-ray or Cobalt Treatment
Y N Hepatitis
Y N Asthma
Y N Sinus Problems
Y N Respiratory Problems
Y N Artificial Bones/Joints
Y N Psychiatric Problems
Y N Congenital Heart Defect
Y N Anemia
Y N High/Low Blood Pressure
Y N Tuberculosis TB
Y N Nervousness
Y N Glaucoma
Y N Cancer/Tumors
Y N Kidney Problems
Y N Shingles
Y N Chemotherapy
Y N HIV+/AIDS/ARC
Y N Difficulty Breathing
Y/N Artificial Valves
Y N Diabetes/Hypoglycemia
Y N Emphysema
Y N Venereal Disease
Y N Chest Pains
Y N Severe/Frequent Headaches
Y N Frequent Neck Pain
Y N Jaw Problems TMJ/TMD

Please list any other surgeries or medical conditions you have or ever had: _______________
_____________________________________________________________________

Are you allergic to any of the following? ___ Latex ___ Penicillin/Amoxicillin ___ Aspirin
___ Tetracycline ___ Dental Anesthetics ___ Others: ________________________________
Do you use tobacco? ___No ___ Yes/How used? ___________ How much? _______ How long? _____
Please rate your general health from 1-10: ______

Have you ever taken the drug Phen-fen and or Redux? ___ Yes ___ No

***For women*****:** Are you taking Birth Control pills? ___ Yes ___No

Are you pregnant? ___ No ___ Yes/How long? __________ Are you nursing? ____ No ___ Yes

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit. If account is not paid within 30 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the Dr. Javaheri and staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

**Signature ____________________________ Date ____/____/____**
__ Adult Patient __ Parent or Guardian __ Spouse