W E L C O M E

PATIENT INFORMATION

Date _____

SS#/Patient ID# _____

Patient _____

Address _____

City _____ State _____ Zip Code_____

E-mail _____

Sex ☐ M ☐ F Birthday _____ Age _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for___years

Occupation _____

Patient Employer/School_____

Employer/School Address_____

_____

Employer/School Phone (___) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Who may we thank for referring you?

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to patient _____

Insurance name _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Name _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr Nahid Hadameh
Name of insurance company (ies)
all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may us my health care information and may disclose such information to the above-insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Person Responsible

_____
Please print name of Patient, Parent, Guardian or Person Responsible

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home (____) _____ Work (____) _____ ext. _____ Alt. Phone (____) _____

Spouse's work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY (Specify someone, who does not live in your household)

Name _____ Phone (____) _____ Relationship _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last x-rays _____

Mark "Yes" or "No" to indicate if you have had any of the following:

Bad Breath __ Yes __ No

Bleeding gums __ Yes __ No

Blisters on lips or mouth __ Yes __ No

Burning sensation on tongue __Yes__No

Chew on one side of mouth __Yes__No

Cigarette, pipe or cigar __Yes__No

Clicking or popping jaw __Yes__No

Dry mouth __Yes__No

Fingernail biting __Yes__No

Food collection between teeth __Yes__No

Foreign objects __Yes__No

Grinding teeth __Yes__No

Gums swollen or tender __Yes__No

Jaw pain or tiredness __Yes__No

Lip or cheek biting __Yes__No

Loose teeth or broken fillings __Yes__No

Mouth breathing __Yes__No

Mouth pain, brushing __Yes__No

Orthodontic treatment __Yes__No

Pain around ear __Yes__No

Periodontal treatment __Yes__No

Sensitivity to cold __Yes__No

Sensitivity to heat __Yes__No

Sensitivity to sweets __Yes__No

Sensitivity when biting __Yes__No

Sore or growths in your mouth __Yes__No

How often do you floss? _____

How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Didronel, Boniva. __Yes __No
Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (Dexfenfluramine). __ Yes __ No
Please mark "Yes" or "No" to indicate if you have had any or the following:

AIDS/HIV	__Yes__No	Epilepsy	__Yes__No	Respiratory Disease	__Yes__No
Anemia	__Yes__No	Fainting or dizziness	__Yes__No	Rheumatic Fever	__Yes__No
Arthritis, Rheumatism	__Yes__No	Glaucoma	__Yes__No	Scarlet Fever	__Yes__No
Artificial Heart Valves	__Yes__No	Headaches	__Yes__No	Shortness of breath	__Yes__No
Artificial Joints	__Yes__No	Heart murmur	__Yes__No	Sinus Trouble	__Yes__No
Asthma	__Yes__No	Heart problems	__Yes__No	Skin Rash	__Yes__No
Back Problems	__Yes__No	Hepatitis type _____	__Yes__No	Special Diet	__Yes__No
Bleeding abnormally, with Extractions or surgery	__Yes__No	Herpes	__Yes__No	Stroke	__Yes__No
		High Blood Pressure	__Yes__No	Swollen Feet or Ankles	__Yes__No
Blood Disease	__Yes__No	Jaundice	__Yes__No	Swollen Neck Glands	__Yes__No
Cancer	__Yes__No	Jaw Pain	__Yes__No	Thyroid problems	__Yes__No
Chemical Dependency	__Yes__No	Kidney Disease	__Yes__No	Tonsillitis	__Yes__No
Chemotherapy	__Yes__No	Liver Disease	__Yes__No	Tuberculosis	__Yes__No
Circulatory Problems	__Yes__No	Low Blood Pressure	__Yes__No	Tumor or growth on head or neck	__Yes__No
Congenital Heart Lesions	__Yes__No	Mitral Valve Prolapse	__Yes__No		
Cortisone Treatments	__Yes__No	Nervous Problems	__Yes__No	Ulcer	__Yes__No
Cough persistent or bloody	__Yes__No	Pacemaker	__Yes__No	Venereal disease	__Yes__No
Diabetes	__Yes__No	Psychiatric care	__Yes__No	Weight loss, unexplained	__Yes__No
Emphysema	__Yes__No	Radiation treatment	__Yes__No		

Do you wear contact lenses? __Yes__No

For Women Only Are you pregnant? __Yes __No Due Date _____ Are you nursing? __Yes __No

Taking birth control pills? __Yes __No

MEDICATIONS

List any medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone (____) _____

ALLERGIES

__ Aspirin
__ Barbiturates (Sleeping pills)
__ Codeine
__ Iodine
__ Other _____
__ Local Anesthetic
__ Penicillin
__ Sulfa
__ Latex
__ None

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? __Yes __No
For what conditions? _____
Are you taking any new medications? __Yes__No If Yes, What? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? __Yes __No
For what conditions? _____

Are you taking any new medications? __Yes__No If Yes, What? _____

Patient Signature _____ Date _____

Doctor's Signature _____ Date _____