PATIENT INFORMATION

CONFIDENTIAL

PATIENT # _____

(PLEASE PRINT)

DATE _____

NAME _____ (FIRST / MI / LAST) BIRTHDATE _____ HOME PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

PATIENT'S OR PARENT/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE _____ CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

E-MAIL _____ CELL PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ FINANCIAL INSTITUTION _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS # _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ UNION OR LOCAL # _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX. ANNUAL BENEFIT? _____

X _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

SIGNATURE

PATIENT NAME

PATIENT NAME		TODAY'S DATE	
HOME ADDRESS		DATE OF BIRTH	
		HOME PHONE	
E-MAIL		CELL PHONE	
BUSINESS ADDRESS		BUSINESS PHONE	
		SS #	

PATIENT MEDICAL HISTORY

PHYSICIAN _____ OFFICE PHONE _____ DATE OF LAST EXAM _____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	❑	❑
2. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	❑	❑
3. ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATIONS ARE YOU TAKING?_____	❑	❑
4. HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	❑	❑
5. DO YOU USE TOBACCO?	❑	❑
6. DO YOU USE ALCOHOL, COCAINE OR OTHER DRUGS?	❑	❑
7. ARE YOU WEARING CONTACT LENSES	❑	❑

8. ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	LOCAL ANESTHETICS (E.G. NOVOCAINE)	❑	❑	BARBITURATES	❑	❑	ASPIRIN
❑	❑	PENICILLIN OR OTHER ANTIBIOTICS	❑	❑	SEDATIVES	❑	❑	OTHER
❑	❑	SULFA DRUGS	❑	❑	IODINE			

	YES	NO
9. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)?	❑	❑
10. WOMEN ONLY:		
A) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	❑	❑
B) ARE YOU NURSING?	❑	❑
C) ARE YOU TAKING BIRTH CONTROL PILLS?	❑	❑

11. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

YES	NO		YES	NO		YES	NO	
❑	❑	HIGH BLOOD PRESSURE	❑	❑	HEART DISEASE	❑	❑	CHEST PAINS
❑	❑	HEART ATTACK	❑	❑	CARDIAC PACEMAKER	❑	❑	EASILY WINDED
❑	❑	RHEUMATIC FEVER	❑	❑	HEART MURMUR	❑	❑	STROKE
❑	❑	SWOLLEN ANKLES	❑	❑	ANGINA	❑	❑	HAY FEVER / ALLERGIES
❑	❑	FAINTING / SEIZURES	❑	❑	FREQUENTLY TIRED	❑	❑	TUBERCULOSIS
❑	❑	ASTHMA	❑	❑	ANEMIA	❑	❑	RADIATION THERAPY
❑	❑	LOW BLOOD PRESSURE	❑	❑	EMPHYSEMA	❑	❑	GLAUCOMA
❑	❑	EPILEPSY / CONVULSIONS	❑	❑	CANCER	❑	❑	RECENT WEIGHT LOSS
❑	❑	LEUKEMIA	❑	❑	ARTHRITIS	❑	❑	LIVER DISEASE
❑	❑	DIABETES	❑	❑	JOINT REPLACEMENT OR IMPLANT	❑	❑	HEART TROUBLE
❑	❑	KIDNEY DISEASES	❑	❑	HEPATITIS / JAUNDICE	❑	❑	RESPIRATORY PROBLEMS
❑	❑	AIDS OR HIV INFECTION	❑	❑	SEXUALLY TRANSMITTED DISEASE	❑	❑	OTHER_____
❑	❑	THYROID PROBLEM	❑	❑	STOMACH TROUBLES / ULCERS			

COMMENTS

SIGNATURE OF DENTIST DATE

PATIENT DENTAL HISTORY

	YES	NO
1. DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	❑	❑
2. ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	❑	❑
3. ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	❑	❑
4. DO YOU FEEL PAIN TO ANY OF YOUR TEETH?	❑	❑
5. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	❑	❑
6. HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	❑	❑
7. HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
A) CLICKING?	❑	❑
B) PAIN (JOIN, EAR, SIDE OF FACE)?	❑	❑
C) DIFFICULTY IN OPENING OR CLOSING?	❑	❑
D) DIFFICULTY IN CHEWING?	❑	❑

	YES	NO
8. DO YOU HAVE FREQUENT HEADACHES?	❑	❑
9. DO YOU CLENCH OR GRIND YOUR TEETH?	❑	❑
10. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	❑	❑
11. HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST?	❑	❑
12. HAVE YOU HAD ANY ORTHODONTIC WORK?	❑	❑
13. HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	❑	❑
14. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING YOUR TEETH?	❑	❑
15. HAVE YOU EVER HAD INSTRUCTIONS ON THE CARE OF YOUR GUMS?	❑	❑

SIGNATURE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ _____

PATIENT, OR PARENT OR GUARDIAN DATE

AZITA ANISSI D.D.S.

Financial Policy

The following is the policy of Azita Anissi, D.D.S.

Payment and copayments for all patients (with insurance or uninsured) for all office services are due on the date of service. We accept various forms of payment including cash, personal check, Visa, Mastercard, Discover, and American Express. We do not offer payment plans.

Cancellation of appointments must be 24 hours prior to the scheduled date. A broken appointment will result in a $50 fee applied to the patient's account and a history of broken appointments may result in dismissal from this practice.

I authorize payment of medical benefits to Azita Anissi, D.D.S. for services rendered and release any medical information required to process the payment claim.

X_____ X_____

Please sign name Please print name

X_____

Date

Azita Anissi D.D.S Privacy Policy

Acknowledgement of Receipt

I acknowledge that a copy of the Azita Anissi D.D.S. Privacy Notice bearing the effective date of January 1, 20_ _ has been made available to me. I have reviewed and I acknowledge the content of this document as indicated by my signature below.

X_____ X_____

Print name Signature

X_____

Date