Reset Form | Print Form

Date: _____ SS/HIC/Patient's ID #: _____

Patient's Name: _____

Home phone: _____

Work phone: _____ Ext: _____

Cell phone: _____

Address: _____

City: _____ State: CA

Zip: _____ email: _____

Sex: _____ Age: _____ Birthdate: _____

◯ Married ◯ Widowed ◯ Single ◯ Minor

◯ Separated ◯ Divorced ◯ Partnered for _____ years

Occupation: _____

Patient Employer/School: _____

Employer/School Address: _____

Spouse's work phone: _____

Spouse's Name: _____

Spouse's work phone: _____ Ext: _____

Birthdate: _____

SSN: _____

Spouse's Employer: _____

Best time and place to reach you _____

Whom may we thank for referring you? _____

Who is responsible for this account? _____

Relationship to patient: _____

Insurance company: _____

Group #: _____

Is patient covered by additional insurance? ◯ Yes ◯ No

Subscriber's name: _____

Birthdate: _____ SSN: _____

Relationship to patient: _____

Insurance company: _____

Group #: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with the ***above-named insurance company(ies)*** and assign directly to ***Dr. David S. Nikfarjam*** 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 dentist may use my health care information and may disclose such information to the above-named 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.

Patient, Parent, Guardian or Personal Representative's signature _____ Date _____

Patient, Parent, Guardian or Personal Representative's name and his/her relationship _____

EMERGENCY CONTACT INFORMATION

(Specify someone who does not live in your household.)

Name: _____

Relationship: _____

Home phone: _____

Work phone: _____

Reason for today's visit: _____

Former Dentist? _____ Date of last dental visit: _____ Date of last dental x-rays: _____

City: _____

State: CA

How often do you floss? _____

How often do you brush? _____

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

Bad breath	◯ Yes	◯ No	Blisters on lips or mouth	◯ Yes	◯ No	Lip or cheek biting	◯ Yes ◯ No
Bleeding gums	◯ Yes	◯ No	Burning sensation on tongue	◯ Yes	◯ No	Loose teeth or broken fillings	◯ Yes ◯ No
			Chew on one side of mouth	◯ Yes	◯ No	Mouth breathing	◯ Yes ◯ No
			Cigarette, pipe, or cigar smoking	◯ Yes	◯ No	Mouth pain, brushing	◯ Yes ◯ No
			Clicking or popping jaw	◯ Yes	◯ No	Orthodontic treatment	◯ Yes ◯ No
			Dry mouth	◯ Yes	◯ No	Pain around ear	◯ Yes ◯ No
			Fingernail biting	◯ Yes	◯ No	Periodontal treatment	◯ Yes ◯ No
			Food collection between the Teeth	◯ Yes	◯ No	Sensitivity to cold	◯ Yes ◯ No
			Foreign objects	◯ Yes	◯ No	Sensitivity to heat	◯ Yes ◯ No
			Grinding teeth	◯ Yes	◯ No	Sensitivity to sweets	◯ Yes ◯ No
			Gums swollen or tender	◯ Yes	◯ No	Sensitivity when biting	◯ Yes ◯ No
			Jaw pain or tiredness	◯ Yes	◯ No	Sores or growths in your Mouth	◯ Yes ◯ No

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Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ◯Yes ◯No

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

AIDS/HIV	◯Yes ◯No	Epilepsy	◯Yes ◯No	Psychiatric Care	◯Yes ◯No
Anemia	◯Yes ◯No	Fainting or dizziness	◯Yes ◯No	Radiation Treatment	◯Yes ◯No
Arthritis, Rheumatism	◯Yes ◯No	Glaucoma	◯Yes ◯No	Respiratory Disease	◯Yes ◯No
Artificial Heart Valves	◯Yes ◯No	Headaches	◯Yes ◯No	Rheumatic Fever	◯Yes ◯No
Artificial Joints	◯Yes ◯No	Heart Murmur	◯Yes ◯No	Scarlet Fever	◯Yes ◯No
Asthma	◯Yes ◯No	Heart Problems	◯Yes ◯No	Shortness of Breath	◯Yes ◯No
Back Problems	◯Yes ◯No	Hepatitis _____	◯Yes ◯No	Sinus Trouble	◯Yes ◯No
Bleeding abnormally, with extractions or surgery			◯Yes ◯No	Skin Rash	◯Yes ◯No
Blood Disease	◯Yes ◯No	Herpes	◯Yes ◯No	Special Diet	◯Yes ◯No
Cancer	◯Yes ◯No	High Blood Pressure	◯Yes ◯No	Stroke	◯Yes ◯No
Chemical Dependency	◯Yes ◯No	Jaundice	◯Yes ◯No	Swollen Feet or Ankles	◯Yes ◯No
Chemotherapy	◯Yes ◯No	Jaw Pain	◯Yes ◯No	Swollen Neck Glands	◯Yes ◯No
Circulatory Problems	◯Yes ◯No	Kidney Disease	◯Yes ◯No	Thyroid Problems	◯Yes ◯No
Congenital Heart Lesions	◯Yes ◯No	Liver Disease	◯Yes ◯No	Tonsillitis	◯Yes ◯No
Cortisone Treatments	◯Yes ◯No	Low Blood Pressure	◯Yes ◯No	Tuberculosis	◯Yes ◯No
Cough, persistent or bloody	◯Yes ◯No	Mitral Valve Prolapse	◯Yes ◯No	Tumor/growth on head/neck	◯Yes ◯No
Diabetes	◯Yes ◯No	Nervous Problems	◯Yes ◯No	Ulcer	◯Yes ◯No
Emphysema	◯Yes ◯No	Pacemaker	◯Yes ◯No	Venereal Disease	◯Yes ◯No
Do you wear contact lenses?	◯Yes ◯No			Weight Loss, unexplained	◯Yes ◯No

Women:

Are you pregnant? ◯Yes ◯No
Taking birth control pills? ◯Yes ◯No
Due Date: _____ Are you nursing? ◯Yes ◯No

List any medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Pharmacy Name: _____

Phone Number: _____

Check next to allergies you might have:

- ☐ Aspirin
- ☐ Sulfa
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin

Other:

_____

_____

_____

---------- *To be filled in at future appintments* ----------

Has there been any change in your health since your last dental appointment? ◯Yes ◯No

Are you taking any new medications? ◯Yes ◯No

If so, what? _____ For what conditions? _____

Patient's Signature: _____ Date: _____ Doctor's Signature: _____ Date: _____

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Patient's Signature: _____ Date: _____ Doctor's Signature: _____ Date: _____