Patient Registration

Please complete the following confidential information

Date_____

PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **MI:**_____

Prefers to be called:_____ **Date of Birth:**_____

Address:_____**City**_____**Zip**_____

Home Ph:_____ **Cell Ph:**_____ **Alt Ph:**_____

Email:_____ **What is the best way to contact you?**_____

Marital Status: Single_____ **Married**_____ **Divorced**_____ **Widowed**_____ **Domestic Partner**_____ **Student**_____ **FT**____ **PT**_____

RESPONSIBLE PARTY

(if different from above)

Last Name: _____**First Name:**_____ **Mi:**_____

Address:_____**City**_____**Zip**_____

Best phone number to be reached at:_____ **Email:**_____

Relationship to patient:_____

INSURANCE INFORMATION

Insurance Company:_____ **Group#:**_____

Employer:_____ **Ph:**_____

Insured's Name:_____ **Date of Birth:**_____

Insured's ID/SS:_____ **Relationship to patient:**_____

Secondary Ins. Co.:_____**Group#**_____

Employer:_____ **Ph:**_____

Insured's Name:_____**Date of Birth:**_____

Insured's ID/SS:_____**Relationship to patient:**_____

GETTING TO KNOW YOU

Is another member of your family or relative a patient in our office? NO YES If so who?_____

How were you referred to our office:
Mailer____ **Newspaper Ad**_____ **Internet**_____ **Insurance**_____ **Drive/Walk by**_____ **Word of mouth**_____

May we have the name of the person who referred you?_____

Person to contact in case of emergency:_____ **Phone:**_____

Address:_____**City**_____**ST**_____**Zip**_____

Closest relative not living with you:_____**Phone:**_____

Address:_____**City**_____**ST**_____**Zip**_____

Dr. Elli Abtahi
Dentistry

Consent for Treatment

1. I hereby authorize Dr. Abtahi, her associate(s), or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.
2. Upon such diagnosis, I authorize Dr. Abtahi / associate(s) to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a compete recital of any possible complications.
4. I give consent to Dr. Abtahi's, associate's or designated staff's use and disclosure of any oral written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.. In the event payments are not received by agreed upon dates, I understand that interest or a service charge may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature:_____ Date:_____

Parent/Responsible Party's Signature:_____

Relationship to patient:_____ Date:_____

Office Witness:_____ Date:_____

MEDICAL HISTORY

Patient Name_____ Medical Alerts_____

Please answer all questions and be sure to mark either Yes or No when applicable.

1. Are you currently under the care of a physician/or have you been within the past 2 years? Yes No
   Physicians Name_____Phone_____
2. Have you taken any medication(s) during the past 2 years? (including non prescription) Yes No
3. Are you currently taking any medications, drugs, pills or herbal remedies, including regular dosage of aspirin Yes No
   Please list name and dosage_____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following? (circle if yes) FenPhen Pondimen Redux Other
   If yes to any of the above, did you have a medical exam for heart issues?
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? Yes No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? Yes No
   If yes, please specify_____
7. Have you been a patient in the hospital during the past (5) five years? Yes No
8. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item:

Heart Surgery, Disease, Attack	Yes	No	Ulcers	Yes	No	Hepatitis A B C (circle one)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	AIDS/HIV Positive	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	Cold Sores/Fever Blisters	Yes	No
High/Low Blood Pressure	Yes	No	Contact Lenses	Yes	No	Blood Transfusion	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Artificial Heart Valve/Pacemaker	Yes	No	Emphysema	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Asthma	Yes	No	Liver Disease/Jaundice	Yes	No
Cortisone Medicine	Yes	No	Hay Fever/Allergy/Hives	Yes	No	Neurological Disorders	Yes	No
Swollen Ankles	Yes	No	Latex Allergy/Sensitivity	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Fainting/Dizzy Spells	Yes	No
Special/Restricted Diet	Yes	No	Radiation Therapy	Yes	No	Cancer	Yes	No
Artificial Joints (hip,knee,etc)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological		
Anemia	Yes	No	Leukemia	Yes	No	care	Yes	No

9. Do you have or have you had any condition, disease, or problem not listed above? Yes No
   Please list_____
10. Have you lost or gained more than 10 pounds in the past year? Yes No
11. **Women**: Are you pregnant, or think you might be? No Yes _____Months Nursing Yes No
12. Do you use birth control prescriptions? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature_____Date_____

History Review:

_____
_____
_____
_____
_____
_____
_____

Doctor Signature_____Date_____

DENTAL HISTORY

Patient Name_____ Medical Alerts_____

Reason for your visit today?_____

_____

Date of last dental visit:_____Last Dental Cleaning_____Last X-rays Taken_____

What was done at your last dental visit?_____

_____

Previous Dentist's Name_____

Address_____Phone_____

How often do you have dental exams?_____

How often do you brush?_____ Floss?_____

Have you ever used or are you currently using topical fluoride? No Yes If yes, what kind?_____

What other dental aids do you use? (Interplak, toothpicks, etc)_____

Do you have any dental concerns now?_____

Are any of your teeth sensitive to:

Hot or Cold	Yes	No
Sweets	Yes	No
Biting/Chewing	Yes	No
Do your gums bleed/hurt	Yes	No
Is there family history of gum disease/tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to get caught in between your teeth?	Yes	No

Do You:

Clench/grind your teeth while awake or asleep?	Yes	No
Bit your lip/cheek regularly?	Yes	No
Hold/chew foreign objects with your teeth?(pencils,pipe,fingernails)	Yes	No
Mouth breathe while awake/ asleep?	Yes	No
Snore/have sleep disorders	Yes	No
Smoke/chew tobacco	Yes	No
Have tire jaws, especially in the morning?	Yes	No

Have you ever had:

Orthodontic treatment	Yes	No
Oral Surgery	Yes	No
Periodontal treatment	Yes	No
Your teeth ground/bite adjusted	Yes	No
Bite plate/mouth guard	Yes	No
Serious injury to the mouth/head	Yes	No

If so, please describe:_____

Have you experienced:

Clicking/popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Have mouth odor/bad taste	Yes	No
Frequent cold sores/blisters or other lesions?	Yes	No
Difficulty in opening /closing the mouth	Yes	No
Difficulty in chewing	Yes	No
Headaches/neckaches/shoulder aches?	Yes	No
Sore Muscles (neck, shoulder)?	Yes	No
Negative/unpleasant dental experience?	Yes	No

Explain:_____

Are you nervous/anxious about dental treatment? Yes No

Have you ever been told to pre-medicate prior to dental treatment? No Yes If yes, please explain why_____

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____