Dr. Najafi And Her Staff Welcome You.

We are here to bring you a beautiful and long lasting smile. Fill out the front and back of this form.

Patient Information (confidential)

Date _____
Email _____
Name _____ **Home Phone** _____
Soc.Sec# _____ **Birth date** _____ **Cell/page Phone** _____

Address _____ City _____ State _____ Zip _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated

If student/college _____ City _____ State _____ ☐ Full time ☐ Part time

Patient's or Parent's Employer _____ Work Phone _____
Business Address _____ City _____ State _____ Zip _____
Spouse or Parent's Name _____ Employer _____ Work Phone _____
Person to Contact in case of emergency _____ Phone _____

Whom May we thank for Referring You? _____

Responsible Party

Name of insurance company (primary) _____ Insured person's name _____
Birthdate _____ Relationship _____ SS# _____ Group# _____
If you have secondary insurance state the name _____

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ City _____ State _____ Zip _____
Driver's License# _____ **Birth date** _____ **SS#** _____
Employer _____ **Home Phone.** _____ **Work Phone** _____
Is this Person a patient in our Office? ☐ YES ☐ NO

Dental History

1. Reason for visit: _____
2. When was your last dental visit? _____
3. If you have changed your dentist, please explain why? _____
4. What do you expect of your dental visits? _____
5. What type of toothbrush do you use? ☐ Sonicare ☐Other electric ☐ regular brush ☐Soft ☐ Medium ☐ Hard

6. Do your gums bleed while brushing or flosing? ☐ YES ☐ NO
7. Are your teeth sensitive to hot, cold, sweet Or sour foods/liquids? ☐ YES ☐ NO
8. Have you noticed any loosening of teeth? ☐ YES ☐ NO
9. Does food tend to become caught between your teeth? ☐ YES ☐ NO
10. Do you have any sores or lumps in or near your mouth? ☐ YES ☐ NO
11. Do you have bad breath ☐ YES ☐ NO
12. Have you experienced any of these problems in your jaw?
    - Clicking ☐ YES ☐ NO
    - Pain (joint, ear, side of face) ☐ YES ☐ NO
    - Difficulty in opening or closing ☐ YES ☐ NO
    - Grinding teeth at night ☐ YES ☐ NO
13. Have you noticed your teeth move or shift ☐Yes ☐No

Are you happy with the appearance of your teeth? please explain. _____

If Not what would you like to change or improve upon? _____

Medical History

Physician's name _____ Phone No_____ _Date last check up _____

Are you now under the care of a physician?	☐ YES ☐ NO	Have you had any abnormal bleeding?	☐ YES ☐ NO
Have you ever been hospitalized explain	☐ YES ☐ NO	Do you bruise easily	☐ YES ☐ NO
Are you taking any medications?	☐ YES ☐ NO	Have you ever required a blood transfusion	☐ YES ☐ NO
if yes, please list _____ _____		Have you had a recent weight loss?	☐ YES ☐ NO
Do you take Aspirin daily? _	☐ YES ☐ NO	Do you use tobacco?	☐ YES ☐ NO
*Women only: *Are you pregnant?	☐ YES ☐ NO	Do you use alcohol?	☐ YES ☐ NO
*Are you nursing?	☐ YES ☐ NO	**Do you use controlled substances?**	☐ YES ☐ NO.
*Are you taking birth control pills?	☐ YES ☐ NO		
Have you ever taken PhenPhen?	☐ YES ☐ NO		
Have you had reactions to any of the following:		Low blood pressure?	☐ YES ☐ NO
Local anesthetics like novocaine?	☐ YES ☐ NO	Hepatitis, jaundice or liver disease?	☐ YES ☐ NO
Penicillin or other antibiotics?	☐ YES ☐ NO	**Stroke?**	☐ YES ☐ NO
Sulfa drugs?	☐ YES ☐ NO	Sinus trouble?	☐ YES ☐ NO
Barbiturates, sedatives or sleeping pills?	☐ YES ☐ NO	Lung or breathing problems?	☐ YES ☐ NO
Latex allergies?	☐ YES ☐ NO		
Do you get heart palpitation or racing when receiving			
Lidocaine	☐ YES ☐ NO	Asthma or hay fever?	☐ YES ☐ NO
Other:_____		Hives or skin rash?	☐ YES ☐ NO
Do you have or have you ever had the following			
Fainting spells or seizures?	☐ YES ☐ NO		
Rheumatic heart disease or rheumatic fever?	☐ YES ☐ NO	**Diabetes**?	☐ YES ☐ NO
Scarlet fever?	☐ YES ☐ NO	AIDS or HIV infection?	☐ YES ☐ NO
Heart defect or heart murmur?	☐ YES ☐ NO	Arthritis or rheumatism?	☐ YES ☐ NO
Heart trouble, heart attach, or angina?	☐ YES ☐ NO	Joint replacement or implant?	☐ YES ☐ NO
Do you have pain in you chest upon exertion?	☐ YES ☐ NO	Thyroid problems?	☐ YES ☐ NO
Are you ever short of breath after mild exercise?	☐ YES ☐ NO	**Stomach ulcer**?	☐ YES ☐ NO
Do your ankles swell?	☐ YES ☐ NO	Kidney trouble?	☐ YES ☐ NO
Do you experience shortness of breath?	☐ YES ☐ NO	Tuberculosis?	☐ YES ☐ NO
Do you require extra pillows when you sleep?	☐ YES ☐ NO	Cancer?	☐ YES ☐ NO
Pacemaker?	☐ YES ☐ NO	Sexually transmitted disease?	☐ YES ☐ NO
Heart surgery?	☐ YES ☐ No	Glaucoma?	☐ YES ☐ NO.
High blood pressure?	☐ YES ☐ NO	Epilepsy?	☐ YES ☐ NO

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsibility to inform the dental office of any medical changes

_____ _____

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN **DATE**

FOR DR. NAJAFI TO FILL:

SUMMARY_____

_____

DATE COMMENTS **PATIENT DENTIST**