

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)

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