REGISTRATION

Please complete this form so that we can provide you with the best possible care.

1. PATIENT INFORMATION

PATIENT'S NAME: LAST FIRST M.I. ***DATE***

WHAT WOULD YOU LIKE TO BE CALLED BY? OCCUPATION

HOME ADDRESS CITY STATE ZIP

PHONE NO. HOME WORK CELL

☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ MINOR SOCIAL SECURITY

E-MAIL DATE OF BIRTH AGE ☐ MALE ☐ FEMALE

IF THIS APPOINTMENT IS FOR A MINOR (UNDER 18 YEARS OLD) STATE YOUR FULL NAME AND RELATIONSHIP TO THE PATIENT:

2. DENTAL INSURANCE AND ACCOUNT INFORMATION

PRIMARY CARRIER:	**SECONDARY CARRIER**
INSURANCE COMPANY	INSURANCE COMPANY
EMPLOYER NAME	EMPLOYER NAME
SUBSCRIBER'S NAME	SUBSCRIBER'S NAME
SUBSCRIBER'S SOCIAL SECURITY NO.	SUBSCRIBER'S SOCIAL SECURITY NO.
ID #	ID #
GROUP #	GROUP #
DATE OF BIRTH RELATIONSHIP TO PATIENT	DATE OF BIRTH RELATIONSHIP TO PATIENT

PERSON FINANCIALLY RESPONSIBLE FOR THE ACCOUNT ☐ PATIENT ☐ SPOUSE ☐ OTHER

NAME: RELATIONSHIP TO PATIENT: SOCIAL SECURITY NO. _ _ _ _ _ _ _ _ _ _ _

ADDRESS:_____

PHONE NO._____

3. PLEASE LET US KNOW

ARE ANY OF YOUR FRIENDS or RELATIVES PATIENT OF OURS? NAME RELATIONSHIP

HOW DID YOU FIND US? ☐ INTERNET **WEBSITE & REVIEWS** ☐ MAIL **COUPONS** ☐ INSURANCE ☐ REFERRAL

WHOM MAY WE THANK FOR REFERING YOU? _____

Patient Name: MEDICAL HISTORY

1. **When was your last complete physical exam?** _____ Last Blood Pressure Level _____ / _____

   Your Physician's Name_____ Phone # _____ Have you had any medical care within the past two years? _____ **Yes** ☐ **No** ☐

   If Yes, Please Describe_____

2. **Are you currently taking any medication?** **Yes** **No,** if yes please list_____

   _____

3. Have you taken any medication or drugs during past two years? **Yes** ☐ **No** ☐, If yes, What? _____

4. Do you routinely take health related or preventive substances such as ***Aspirin***, Garlic, Vitamin, Herbals, etc? **Yes** ☐ **No** ☐

   If yes, please list _____

5. Have you ever taken prescription medication for weight loss (Diet Pills) such as Fen-Fen, Pondimen, Redux, and Other_____. If yes, did you have a medical exam for heart tissue? …… **Yes** ☐ **No** ☐

6. Have you ever taken medication for prevention of bone loss such as Fosamax, Actonel, Boniva, or other? **Yes** ☐ **No** ☐

7. **Have you been hospitalized during past five years?** …… **Yes** ☐ **No** ☐

8. Do you have to be pre-medicated with Antibiotic Prophylaxis before your dental treatments? …….. **Yes** ☐ **No** ☐

9. Have you experienced any of the following? (Please circle Yes or No):

Chest pain (angina)	Yes No	Blood in stool	Yes No	Frequent vomiting	Yes No
Fainting spells	Yes No	Diarrhea/constipatic	Yes No	Jaundice	Yes No
Fever	Yes No	Frequent urination	Yes No	Dry mouth	Yes No
Night sweats	Yes No	Difficulty urinating	Yes No	Excessive thirst	Yes No
Persistent cough	Yes No	Ringing in ears	Yes No	Difficulty swallowing	Yes No
Coughing up blood	Yes No	Headaches	Yes No	Swollen ankles	Yes No
Bleeding problem	Yes No	Dizziness	Yes No	Joint pain or stiffness	Yes No
Blood in urine	Yes No	Blurred vision	Yes No	Shortness of breath	Yes No
Significant weight loss	Yes No	Bruise easily	Yes No	Sinus problems	Yes No

10. Have you had or do you have any of the following? (Please circle Yes or No):

Heart disease……	Yes No	Ulcers……	Yes No	Hepatitis A……	Yes No
Heart attack……	Yes No	Diabetes……	Yes No	Hepatitis B or C……	Yes No
Heart surgery……	Yes No	Thyroid problems……	Yes No	AIDS/ HIV……	Yes No
Heart murmur……	Yes No	Glaucoma……	Yes No	Hemophilia……	Yes No
High blood pressure	Yes No	Kidney trouble……	Yes No	Sickle cell disease……	Yes No
Mitral valve prolapsed….	Yes No	Liver disease……	Yes No	Venereal disease……	Yes No
Artificial heart valve……	Yes No	Emphysema……	Yes No	Skin disease……	Yes No
Rheumatic fever……	Yes No	Asthma……	Yes No	Neurological disorders….	Yes No
Arthritis/Rheumatism……	Yes No	Hay fever/allergy/hives…	Yes No	Epilepsy or seizures……	Yes No
Cortisone medicine……	Yes No	Tumors or cancer……	Yes No	Nervous/anxious……	Yes No
Stroke……	Yes No	Chemo/Radiation therapy	Yes No	Psychiatric care……	Yes No
Artificial joints ……	Yes No	Tuberculosis……	Yes No	Psychological care……	Yes No

11. **Are you <u>allergic</u> to or have you had a reaction to any of the following?** (If yes, please circle or write)

☐ Aspirin ☐ Codeine ☐ Valium ☐ Penicillin ☐ Local Anesthetic ☐ Latex ☐ Food ☐ Metal

☐ Darvon ☐ Demerol ☐ Vicodin ☐ Erythromycin ☐ Nitrous Oxide ☐ Percodan ☐ tetracycline

Others: _____

12. Do you currently use any recreational drugs? ☐ **Yes** ☐ **No**
13. Have you ever used any recreational drugs? ☐ **Yes** ☐ **No,** if yes when did you stop using? _____

14. Do you have or have had any disease, condition, or problem not listed in this form? ..... ☐ **Yes** ☐ **No**
    If yes, please list: _____

15. Do you smoke cigarette or use tobacco in any form? ☐ **Yes** ☐ **No** if yes are you interested in quitting? ☐ **Yes** ☐ **No**
16. Do you drink alcohol? ☐ **Yes** ☐ **No,** if yes # of drinks per week**?** _____

17. **Woman**:
    Are you pregnant or think you are pregnan ☐ **Yes** ☐ **No** if yes what month?_____ Nursing ☐ **Yes** ☐ **No**
    Are you using birth control prescriptions? ☐ **Yes** ☐ **No**
    Are you under any Hormone Therapy? ☐ **Yes** ☐ **No**

Note: I certify that I have read and understand this form. I have answered all of the questions to the best of my knowledge. I understand the above information is necessary for having a safe and efficient dental care. If any further health history information is needed, you have my permission to ask the respective health care provider or agency for a release of such information to you. It is my responsibility to notify the dentist in this facility of any change in my health or medication. Further, I will not hold my dentist or any other member of staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) X_____, **Date** _____

History Review by the Dentist: **ASA. I II III IV**

BP ____ /____

HR ____ / Min.

Dentist Signature X_____ Date:_____

MEDICAL HISTORY UPDATES

I have reviewed my Medical History and confirm that it accurately states past and present condition.

DATE	PATIENT SIGNATURE	CHANGES TO MEDICAL HISTORY	DENTIST INITIAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: DENTAL HISTORY

Reason for your visit today:_____

Date of last dental visit _____ last dental cleaning _____ Last full mouth X-rays_____

Reason for your last dental visit _____ previous dentist's name _____

City/State_____Telephone_____

Do you brush your teeth? ☐ Yes ☐ No **How Often?** _____

Do you floss? ☐ Yes ☐ No **does your gum bleed when you are flossing?** ☐ Yes ☐ No

Do you have pain or sensitivity to?

HOT or COLD? ☐ Yes ☐ No SWEET? ☐ Yes ☐ No BITING OR CHEWING? ☐ Yes ☐ No

Do you frequently have? Cold Sore ☐ Yes ☐ No Burning sensation on tongue ☐ Yes ☐ No
Dry Mouth ☐ Yes ☐ No

Have your parents experience gum disease or tooth loss? ☐ Yes ☐ No
Have you noticed any mouth odor or bad tastes? ☐ Yes ☐ No Do your gums bleed or hurt? ☐ Yes ☐ No
Does food gets caught in between your teeth? ☐ Yes ☐ No Any change in your bite? ☐ Yes ☐ No

Do you: (Please circle Yes or No)

Clench or Grind your teeth?	Yes	No
Bite your lip or cheeks regularly?	Yes	No
Bite on Fingernails, pencil, or etc.?	Yes	No
Have tired jaw, mostly in the morning?	Yes	No
Snore or have any other sleep disorders?	Yes	No
Smoke or chew tobacco or its products?	Yes	No
Mouth breathing while awake or sleep?	Yes	No

Have you ever Experience? (Please circle Yes or No)

Clicking or popping of your jaw?	Yes	No
Pain around the ear or side of the face?	Yes	No
Difficulty opening or closing the mouth?	Yes	No
Difficulty in chewing?	Yes	No
Headaches, neck, and shoulder aches?	Yes	No
Sore neck and shoulder muscles?	Yes	No

Have you ever had: (Please circle Yes or No)

Orthodontic Treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth and bite adjusted?	Yes	No
A bite plate or night guard?	Yes	No
Serious head or mouth injury?	Yes	No

Do you feel nervous when having dental treatment? Yes No
If yes, what is your biggest concern? _____
Have you ever had an upsetting dental experience? Yes No
If yes, Pleas describe_____
_____

Are you happy with your teeth appearance? ☐ Yes ☐ No
If no, what is it that you want to improve?_____

Is there anything else about your dental history or dental treatment that you would like us to know?
If yes, please explain _____

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OFFICE POLICIES

- **PAYMENT:** Payment is expected at the time of service unless prior financial arrangements have been made. If you have dental insurance, our staff will give you an estimate of your insurance benefits and your co-payment, which is *due at the time of service*. Verification of your insurance benefits never guarantees payment and whatever charges occur is ultimately *your responsibility.* For your convenience, we accept VISA, MasterCard, Discover, and American Express, as well as personal checks. There will be a $25.00 fee for returned checks. I understand that if my account remains unpaid by me for 30 days, it may be referred to an attorney for collections and that I further agree to be responsible and pay for all cost incurred, including attorney fees and 10% annual interest.

CANCELLATIONS: When you schedule an appointment at our office, time is set-aside specifically for you and your treatment. It is very important that your keep your appointment, or if needed, reschedule it as soon as possible. We require at least 24 working hours notice if you must reschedule your treatment. Missed appointments and those cancelled with less than one day's notice will be subjected to $50.00 charge the first time and a $100.00 charge each additional time. No further appointments will be made until missed appointment fee is paid.

FORWARDING X-RAYS: If you request your x-rays to be sent to a subsequent dentist, they will be copied and forward for $25.00. This fee and any remaining balance must be paid before the forwarding will occur. If we refer you to a specialist and they require an x-rays we already have on file, no fee will be charged.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGE & RECEIPT OF DENTAL MATERIALS FACT SHEET:

By signing below, I acknowledge that I have received and understand this office's Notice of Privacy Practices. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If changes occur, the office will provide me with a revised Notice upon request. Also, by signing below, I acknowledge that I have received a copy of the Dental Materials Fact sheet, as required by law.

TREATMENT: I hereby allow doctor or designated staff to take necessary x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis. I agree to the use of anesthetics, sedative, and other medication as necessary for my dental treatments. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

INSURANCE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with_____and assign directly to Arash Razi, DDS. Inc. /Mission Hills Dental 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. Arash Razi, DDS Inc. may use my health care information and may disclose such information to the above insurance company (ies) and their agents for the purpose of obtaining payments for services.

_____ x_____

Please Print Patient Name **Patient/Guardian Signature** **Date**