

DENTAL REGISTRATION AND HISTORY

1

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
 Last Name _____
 First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)

Dr. _____ 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.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____ Relationship to Patient _____

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PHONE NUMBERS

Phone (_____) _____ Work (_____) _____ Ext _____ Cell (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

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DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

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HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

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

Place a mark on "yes" or "no" to indicate if you have had any of the following:

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

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

ALLERGIES

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

Pharmacy Name _____

Phone (_____) _____

☐ Aspirin

☐ Local Anesthetic

☐ Barbiturates (Sleeping pills)

☐ Penicillin

☐ Codeine

☐ Sulfa

☐ Iodine

☐ Other _____

☐ Latex

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UPDATES (To be filled in at future appointments)

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

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____



Dr. Ava Parakhoodi, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read the laminated copy of privacy practice, and I am aware that a copy of this document is available upon request at any time.

Print Name

Patient Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)



Dr. Ava Parakhoodi, DMD

Financial Agreement

I understand my dental insurance is a contract between the insurance carrier and me, not between Dr. Parakhoodi and the insurance carrier. Therefore, I am responsible for all dental fees. I understand I will be charged for all dental treatment and that any payment received by Dr. Parakhoodi from my insurance carrier will either be credited to my account or refunded to me if I have paid the dental fee incurred. Any fees not paid by my insurance **60 DAYS** after treatment are my responsibility.

Patient Signature

Date

Missed Appointments/Cancellation Policy

Our policy is to charge for missed appointments as the rate of no less than \$50 per visit and no more than the cost of the appointment. Please help us serve you and our other patients by keeping scheduled appointments. Appointments that are canceled or changed less than 24 hours from the time of the appointment become time lost for the office and for our other patients. We require you to inform our office of a cancellation or need to reschedule of any appointment at least one business day, 24 hours before the appointment (ex. A Monday 9am appointment needs to be canceled by 9am the Friday before). Cancellations made with less than 24 hours' notice may result in a charge of no less than \$50 and no more than the cost of the appointment. Due to the nature of the practice of dentistry, and the advanced planning of all major treatment, such notice is mandatory.

Patient Initials