El Dorado Hills Cosmetic, Implant & Family Dentistry

www.DrJonahTabrizi.com info@DrJonahTabrizi.com
993 Governor Dr., Suite 104 • El Dorado Hills, CA 95762 (916)941-1515

Medical & Dental History Form

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Please Check Yes or No for any of the following:

Allergies *	◯ Yes ◯ No	Alzheimer's *	◯ Yes ◯ No
Amoxicillin Allergy *	◯ Yes ◯ No	Anemia *	◯ Yes ◯ No
Arthritis *	◯ Yes ◯ No	Artificial Joints *	◯ Yes ◯ No
Asthma *	◯ Yes ◯ No	Blood Disease *	◯ Yes ◯ No
Cancer *	◯ Yes ◯ No	Codeine Allergy *	◯ Yes ◯ No
Demerol Allergy *	◯ Yes ◯ No	Diabetes *	◯ Yes ◯ No
Dizziness *	◯ Yes ◯ No	Epilepsy *	◯ Yes ◯ No
Epinephrine Allergy *	◯ Yes ◯ No	Epiniephrine Allergy *	◯ Yes ◯ No
Excessive Bleeding *	◯ Yes ◯ No	Fainting *	◯ Yes ◯ No
Glaucoma *	◯ Yes ◯ No	Growths *	◯ Yes ◯ No
Hay Fever *	◯ Yes ◯ No	Head Injuries *	◯ Yes ◯ No
Heart Disease *	◯ Yes ◯ No	Heart Murmur *	◯ Yes ◯ No
Hepatitis *	◯ Yes ◯ No	High Blood Pressure *	◯ Yes ◯ No
High Cholesterol *	◯ Yes ◯ No	HIV *	◯ Yes ◯ No
Jaundice *	◯ Yes ◯ No	Kidney Disease *	◯ Yes ◯ No
Latex Allergy *	◯ Yes ◯ No	Liver Disease *	◯ Yes ◯ No
Mental Disorders *	◯ Yes ◯ No	Multiple Sclerosis *	◯ Yes ◯ No
MVP *	◯ Yes ◯ No	Neck Surgery *	◯ Yes ◯ No
Nervous Disorders *	◯ Yes ◯ No	No Pre Med *	◯ Yes ◯ No
Osteoporosis Med *	◯ Yes ◯ No	Other *	◯ Yes ◯ No
Pacemaker *	◯ Yes ◯ No	Penicillin Allergy *	◯ Yes ◯ No
Phen-fen *	◯ Yes ◯ No	Pre Med *	◯ Yes ◯ No
Pregnancy *	◯ Yes ◯ No	Radiation Treatment *	◯ Yes ◯ No
Respiratory Problems *	◯ Yes ◯ No	Rheumatic Fever *	◯ Yes ◯ No
Seizures *	◯ Yes ◯ No	Sinus Problems *	◯ Yes ◯ No
STD *	◯ Yes ◯ No	Stomach Problems *	◯ Yes ◯ No
Stroke *	◯ Yes ◯ No	Sulfa Allergy *	◯ Yes ◯ No
Sulfa Allergy *	◯ Yes ◯ No	Taking Medications *	◯ Yes ◯ No
Thyroid Condition *	◯ Yes ◯ No	Tuberculosis *	◯ Yes ◯ No
Tumors *	◯ Yes ◯ No	Ulcers *	◯ Yes ◯ No

Do you have any other allergies, conditions, diseases, etc., not previously listed that we should be aware of? * ◯ Yes ◯ No

If Yes, please list below:

_____

_____

Please list any medications you are currently taking, one medication per line:

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam? _____

Your Primary Care Physician's name, address, & phone number:

Please Check Yes or No for any of the following:

Are you currently under the care of a physician due to a specific condition? * ◯ Yes ◯ No

Within the past year has there been any change to your health? * ◯ Yes ◯ No

Have you been hospitalized within the last 5 years due to a surgery or illness? * ◯ Yes ◯ No

Do you use tobacco (smoking or chewing)? * ◯ Yes ◯ No

Do you require the use of corrective lenses (contacts or glasses)? * ◯ Yes ◯ No

If any of the previous questions are marked yes, please explain:

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)? _____

Prior Dentist's name, address, & phone number:

Have you ever had any complications or been dissatisfied with dental treatment? ◯ Yes ◯ No

If Yes, please explain below:

Please Check Yes or No for any of the following:

Do your gums bleed when you brush or floss? * ◯ Yes ◯ No

Do your teeth experience sensitivity to cold or hot temperatures? *
◯ Yes ◯ No

Are any of your teeth currently causing you pain? *
◯ Yes ◯ No

Do you grind your teeth (either consciously or during sleep)? *
◯ Yes ◯ No

Are any of your teeth loose, or are you concerned about any teeth loosening? *
◯ Yes ◯ No

Do you currently have any dental implants, dentures, or partials? * ◯ Yes ◯ No

How frequently do you brush your teeth?
◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?
◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Patient Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

*Treatment (including direct or indirect tretment by other healthcare providers involved in my treatment);
*Obtaining payment from third party payers (e.g. my insurance company);
*The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occured prior to the date I revoke this consent is not affected.

Signature _____ **Date** _____

Response Date: _____