American Dental Solutions

Mehjabeen Zahirsha DDS

1. ABOUT YOU

Date: ____________

Patient Name: ______________________
Last First Middle

Preferred Name: ____________ ☐ Male ☐ Female

Birth date: ____________ Age: ____ SSN# ____________

Mailing Address: ______________________

____

Home Phone: ____________ Cell: ____________

Work Phone: ____________

E-mail address: ______________________

Employer: ____________ How long? ________

Employer's Address:

____

____

Occupation: ____________

Status: ☐ Minor ☐ Single ☐ Mrried ☐ Divorced
☐ Separated ☐ Widowed

Spouse's name: ____________

Do you have Children? ☐ Yes ☐ No How many? ____

2. IN EVENT OF EMERGENCY

Whom should we contact? ____________

Relation: ____________

Home Phone: ____________ Work Phone: ____________

Cell Phone: ____________

Who is your Medical/family Doctor? ____________

Medical/Family Doctor phone #: ____________

3. INSURANCE INFO

Primary Insurance: ____________

Phone: ____________

Insurance ID # ____________

Group ID# ____________

Insured's Name: ____________

Insured's Employer Name: ____________

Secondary Insurance: ____________

Insurance ID # ____________

Group ID# ____________

Insured's Name: ____________

4. ACCOUNT INFO

Person Ultimately responsible for payment

Name: ____________

Relation: ____________

Billing Address: ____________

____

SSN #: ____________

Drivers License # : ____________

Work Phone #: ____________

________ I hereby authorize assignment of my
initial
insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (if offered at this office)

5.REFERRALS

How did you hear about us?

☐ Phone Book ☐ Direct mail

☐ New paper ☐ Internet

☐ Others ____________

☐ Referred by: ____________

Please fill out all the information on both sides

6. DENTAL INFORMATION

Reason for today's visit: □ Exam □ Emergency □ Consultation
Are you in pain? : □ Yes □ No How Long? ___________
Please indicate ■ any of the following problems:
□ Discomfort, clicking or popping in jaw □ lost/Broken Filling(s) □ Stained teeth □ Red, swollen or bleeding gums □ Teeth grinding
□ Locking Jaw □ Sensitive tooth, teeth or gums □ ringing in Ears □ Bad breath □ Blisters/Sores in or around the mouth
□ Broken/Chipped tooth □ Others ___________
Do you require pre-medication? □ Yes □ No □ Don't know

Previous Dentist : Dr ___________ Phone No: ___________
Last Dental Exam: ____/____/____ Last Dental X-rays: ____/____/____

How many times a day you brush? ____ How many times week you floss?: ____

What type of tooth brush bristles do you use? □ Soft □ Medium □ Hard Do you use Sonic brushes? □ Yes □ No □

How would you rate your smile ? 1 2 3 4 5 6 7 8 9 10

(Worst) 1 (Best) 10

7. MEDICAL INFORMATION

What medications are you taking? □ Nerve pills □ Pain Killers □ Asprin □ Muscle relaxes □ Stimulants □ Blood thinners
□ Tranquilizers □ Insulin □ Medication for osteoporosis □ Other(s), please list ___________

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	Y N Thyroid Problems	Y N Cancer/Tumors	Y N Cosmetic Surgery
Y N Heart Surg/Pace maker	Y N Kidney Problems	Y N Shingles	Y N Xray or Cobalt Treatment
Y N Heart Murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral valve prolpse	Y N Sinus problems	Y N Arthritis/ Rheumatism	Y N Difficulty Breathing
Y N Artificial Valves	Y N Stomach problem /Ulcers	Y N Artificial Bones/Joints	Y N Diabetes/Hypoglycemia
Y N Heart Disease	Y N Psychiatric problem	Y N Emphysema	Y N Leukemia
Y N Congenital Heart Defect	Y N Venereal Disease	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Alcohol/Drug Abuse	Y N Severe/Freqt. Headache	Y N High/Low Blood pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck pain	Y N Bleeding problem
Y N Nervousness	Y N Jaw Problem TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ___________
Are you allergic to ny of the following? □ Latex □ Penicillin / Amoxicillin □ Tetracycline □ Asprin □ Dental Anesthetics
□ Foods: ___________ □ Others: ___________
Do you use tobacco? □ No □ Yes How used? ___________ How much? ________ How long? ________
Please rate your general health from scale 1- 10 (10 excellent) ________ Do you wear contact lenses? □ Yes □ No □
Have you ever taken the drug Phen-fen and or Redux? □ Yes □ No
FOR WOMEN: Are you taking Birth Control pills? □ Yes □ No How many children do you had? ________
Are you pregnant? □ Yes □ No How long? ________ Are you nursing? □ Yes □ No

□ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
□ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with business manager. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges 18% per annuam and any other expenses incurred in collecting your account.
□I I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
□ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ___________ Date: ____/____/____
□ Adult Patient □ Parent or Guardian □ Spouse