

PATIENT INFORMATION

PATIENT

Name _____
 Address _____ Apt. # _____
 City _____ Zip Code _____
 How long at this address? _____
 Telephone () _____
 Cell/Pager () _____
 E-mail _____
 Social Security # _____ DL# _____
 Age _____ Birthdate _____

Responsible Party (If same as above, please skip)

Name _____
 Address _____ Apt. # _____
 City _____ Zip Code _____
 How long at this address? _____
 Telephone () _____
 Cell/Pager () _____
 E-mail _____
 Social Security # _____ DL# _____
 Relationship to patient _____
 Age _____ Birthdate _____

EMPLOYMENT

Occupation _____
 Employer _____
 How Long? _____
 Business Address _____
 City _____ Zip Code _____
 Business Phone () _____ Ext. # _____
 Verified By _____ Date _____

REFERENCES

Name _____
 Address _____ Apt. # _____
 City _____ Zip Code _____
 Telephone () _____
 Name _____
 Address _____ Apt. # _____
 City _____ Zip Code _____
 Telephone () _____
 Spouses Name _____
 Spouse's Work # () _____

EMERGENCY CONTACT

Name _____
 Address _____ Apt. # _____
 City _____ Zip Code _____
 Telephone () _____

GETTING TO KNOW YOU

Are there other members of your household who are not patients at our office?
 Yes ___ No ___ Please list names and relationship (son, daughter, husband):
 1: _____ 2: _____
 3: _____ 4: _____
 How did you hear about our office?
 Doctor's Referral _____ Doctor's Name: _____
 Yellow Pages _____ Printed Material _____
 Insurance Plan _____ Walk in Sign _____ Family or Friend _____
 TV _____ Radio _____ Billboard _____ Website _____

INSURANCE
Primary Insurance

Name _____
 Address _____
 City _____ Zip code _____
 Telephone () _____
 Employer _____
 Union/local _____ Group # _____
 Insurer's Name _____
 Insured's Soc Sec No _____ Birthdate _____

Secondary Insurance

Name _____
 Address _____
 City _____ Zip Code _____
 Telephone () _____
 Employer _____
 Union/local _____ Group # _____
 Insured's Name _____
 Insured's Soc Sec # _____ Birthdate _____

MANAGED CARE PLAN (HMO)

Plan Name _____
 Group # _____ Plan# _____
 Employer _____
 Insured's Name _____
 Insured's Soc Sec # _____

1. I hereby certify that the above information is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that Total Care Dental provides business support services to independent dentists and recognize that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Keivan Sarraf DDS, Inc or its subsidiaries is responsible for my dental treatment.

Signature _____ Date _____

GENERAL HEALTH INFORMATION

Date: _____

Patient Name: _____

Birth Date: _____

Age: _____

LAST

FIRST

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No If yes, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
 Pregnant / Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other please explain: _____

Do you have, or have you had, any of the following? (Please fill in the circles completely ie. ●)

AIDS/HIV+	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Wounded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above? Yes No _____

Comments: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

Patient signature or parent if patient is a minor _____

Date _____

Doctor Signature _____

Date _____

UPDATE TO MEDICAL HISTORY

Date	Comments	Patient Signature	Doctor Signature