

WELCOME



Naghmeh J Izadi
DMD

Adult Dental Registration and History

Thank you for selecting our dental team. We will always offer you the highest quality dental care available. In order to help us better serve you, please fill out these forms in their entirety. We look forward to serving you and your family.

1	Dental Information
Date _____	
Patient Name: _____	
Preferred Name: _____	
Address: _____	
State _____ Zip Code _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Age: _____ Birthday: _____	
Patient SSN: _____	
Patient driver license number: _____	
Occupation: _____	
Employer: _____	
Employer Address: _____	
Employer Phone: _____	
Spouse's Name: _____	
Birthday: _____ SSN: _____	
Occupation: _____	
Spouse's Employer: _____	
Whom may we thank for referring you? _____	

2	Account's Responsible Party
Person who is responsible for this account: _____	
Relationship to patient: _____	
DOB: _____ SSN: _____	
Driver Lic #: _____	
Do you have dental benefit plan? _____ Yes _____ No	
Dental Insurance	
Insurance Company: _____	
Insurance Phone: _____	
Group Number: _____	
Subscriber's Name: _____	
Subscriber's SSN/ID#: _____	
Subscriber's Driver License #: _____	
Relationship to patient: _____	
Is patient covered by additional insurance? _____ Yes _____ No	
Insurance Company: _____	
Insurance Phone: _____	
Group Number: _____	
Subscriber's Name: _____	
SSN/ID #: _____ Driver Lic. #: _____	
Relationship to patient: _____	
Assignment and Release:	
I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Izadi 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.	
_____ Responsible Party Signature	
Relationship	Date

3	Contact Information
Email address _____	
Home # _____	
Cell # _____	
Work # _____ Ext _____	
Spouse's Phone # _____	
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 _____	

4	Dental History	
Reason for today's visit _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Cigarette, pipe or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/ State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Dentures <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Partial dentures <input type="checkbox"/> Yes <input type="checkbox"/> No
Please mark "Yes" or "No" to indicate if you have had any of the following:	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gum <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Braces <input type="checkbox"/> Yes <input type="checkbox"/> No	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Gum surgery <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? _____

Please continue on the next page!

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Health History

Are you under a Physician's care? _____ No _____ Yes, Reason: _____

Physician's Name: _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina (Chest pain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	HPV (human Papilloma Virus)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<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	Swelling of Feet or ankles	<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	Swollen Neck Glands	<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	Thyroid Problems	<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	Tonsillitis	<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	Tuberculosis	<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	Tumor or growth on head or neck	<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	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:		Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date _____			
		Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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Medications

Have you ever taken any Bisphosphonates or other medications for Osteoporosis? _____ Yes _____ No

List medications you are currently taking: _____

Pharmacy Name: _____

Phone: _____

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Allergies

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (Sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

Patient's Signature _____ Date: _____

Thank you!

Dr. Izadi's Office Use Only

Dr.'s Notes: _____

Dr.'s Signature _____ Date: _____