Thank you for visiting the office of Dr. Sohrab Saghezchi. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name ____
LAST FIRST MIDDLE PREFERRED

Address ____
STREET CITY STATE ZIP

Birth Date ___________________ Social Security # _________________________ Driver License ______________________________

Email ____ Employer/School ________________________________

Phone: Home (__________)________________________ ☐ Male ☐ Female

Work (__________)________________________ ☐ Married ☐ Single ☐ Other

Cell (__________)________________________

Emergency Contact: Name ______________________________________ Phone (__________)______________________

How did you hear about us? ☐ Website ☐ Internet Search ☐ Insurance ☐ Walk-in/Drive By

☐ Referred by: ____ ☐ Other ____

Insurance

Primary Dental Carrier

Insurance Co Name: ____ Phone # ________________________________

Insured's Name: ______________________________________ Birth Date: _________________ ID#: ______________________

Insured's Employer: ____ Group #: _______________________________

Secondary Dental Carrier

Insurance Co Name: ____ Phone # ________________________________

Insured's Name: ______________________________________ Birth Date: _________________ ID#: ______________________

Insured's Employer: ____ Group #: _______________________________

If Patient Is Under 18 Years Of Age

Responsible Party ____ Relation to Patient ______________________________________

The information on this page is correct to the best of my knowledge

____ ___________________________

PATIENT OR PARENT/GUARDIAN **SIGNATURE** DATE

Dental History

What is the reason for your visit today? ______________________________

Date of Last Dental Visit ________________ Last Dental Cleaning ________________ Last Full Mouth X-Rays ________________

What was done at your last dental visit? ______________________________

Previous Dentist's Name ______________________________ Telephone ________________________

How often do you brush your teeth? ______________________ How often do you floss? ______________________

What other dental aids do you use? (toothpick, Waterpik, mouthwash, etc.) ______________________________

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: ______________________________

Are any of your teeth sensitive to:	Yes	No
Hot or Cold?	☐	☐
Sweets?	☐	☐
Biting or Chewing?	☐	☐
Have you noticed any mouth odors/bad tastes?	☐	☐
Do you frequently get cold sores, blisters or any other oral lesions?	☐	☐
Do your gums bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food tend to get caught between teeth?	☐	☐

If yes, where? ______________________________

Do you:	Yes	No
Clench or grind your teeth while awake or asleep?	☐	☐
Bite your lips or cheeks regularly?	☐	☐
Hold foreign objects with your teeth? (pencils/pens, pipe, pins, nails, fingernails)	☐	☐
Mouth breathe while awake or asleep?	☐	☐
Have tired jaws, especially in the morning?	☐	☐
Smoke/chew tobacco?	☐	☐
Use recreational drugs?	☐	☐
Drink alcohol?	☐	☐

Have you ever had:	Yes	No
Orthodontic treatment?	☐	☐
Oral Surgery?	☐	☐
Periodontal treatment?	☐	☐
Your teeth ground or the bite adjusted?	☐	☐
A bite plate or mouth guard?	☐	☐
A serious injury to the mouth or head?	☐	☐

If so, please describe, including cause

____

Have you experienced:	Yes	No
Clicking or popping of the jaw?	☐	☐
Pain? (joint, ear, side of face)	☐	☐
Difficulty opening or closing the mouth?	☐	☐
Difficulty chewing?	☐	☐
Headaches, neckaches or shoulder aches?	☐	☐
Sore muscles? (neck, shoulders)	☐	☐

	Yes	No
Are you happy with your smile?	☐	☐
Would you like straighter teeth?	☐	☐
Would you like whiter teeth?	☐	☐
Would you like to keep all of your teeth?	☐	☐
Do you feel nervous about having dental treatment?	☐	☐

If so, what is your biggest concern?

____

	Yes	No
Have you ever had an upsetting dental experience?	☐	☐

If yes, please describe

____

Is there anything else about having dental treatment that you would like us to know? Yes ☐ No ☐

If yes, please describe ______________________________

____

____

Medical History

Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If yes, for what? ____

Physician's Name _____________________________________ Phone ______________________________

Address ____ City _________________________ State ______ Zip _____________

Have you taken any medication or drugs in the past two years? Yes ☐ No ☐

Are you taking any medication, drugs or pills now, including regular dosages of aspirin? Yes ☐ No ☐

If yes, please list name and dosage ____

Have you taken any of the following for weight loss? Yes ☐ No ☐
Fen-Phen (Fenfluramine-Phentermine), Pondimin (Fenfluramine), Redux (Dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? Yes ☐ No ☐

Have you ever taken any Bisphosphonates? (e.g. Fosamax, Actonel) Yes ☐ No ☐

Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? Yes ☐ No ☐

If yes, please list: ____

Have you been a patient in the hospital during the past five years? Yes ☐ No ☐
Indicate which of the following you have had, or have at present. Check "yes" or "no" box for each item.

	Yes	No		Yes	No		Yes	No
Heart (Surgery,Disease,Attack)	☐	☐	Ulcers	☐	☐	Hepatitis A (infectious) B (serum)	☐	☐
Chest Pain	☐	☐	Diabetes	☐	☐	Venereal Disease	☐	☐
Congenital Heart Disease	☐	☐	Thyroid Problems	☐	☐	A.I.D.S or H.I.V Positive	☐	☐
Heart Murmur	☐	☐	Glaucoma	☐	☐	Cold Sores/Fever Blisters	☐	☐
High Blood Pressure	☐	☐	Contact Lenses	☐	☐	Blood Transfusion	☐	☐
Mitral Valve Prolapse	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐
Artificial Heart Valve	☐	☐	Chronic Cough	☐	☐	Sickle Cell Disease	☐	☐
Heart Pacemaker	☐	☐	Tuberculosis	☐	☐	Bruise Easily	☐	☐
Rheumatic Fever	☐	☐	Asthma	☐	☐	Liver Disease	☐	☐
Arthritis/Rheumatism	☐	☐	Hay Fever	☐	☐	Yellow Jaundice	☐	☐
Cortisone Medicine	☐	☐	Latex Sensitivity	☐	☐	Neurological Disorders	☐	☐
Swollen Ankles	☐	☐	Allergies or Hives	☐	☐	Epilepsy or Seizures	☐	☐
Stroke	☐	☐	Sinus Trouble	☐	☐	Fainting or Dizzy Spells	☐	☐
Diet (Special/Restricted)	☐	☐	Radiation Therapy	☐	☐	Nervous/Anxious	☐	☐
Artificial Joints (hip,knee,etc.)	☐	☐	Chemotherapy	☐	☐	Psychiatric/Psychological Care	☐	☐
Kidney Trouble	☐	☐	Tumors	☐	☐			

Do you have or have you had any disease, condition, or problem not listed? Yes ☐ No ☐

If yes, please list: ____

Women, Are you:
Pregnant? Yes ☐_____ Months No ☐ **Nursing?** Yes ☐ No ☐ **Taking birth control pills?** Yes ☐ No ☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature ____ Date ________________

Dentist Comments: ____

Dentist Signature ____ Date ________________