

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date: _____ Whom may we thank for referring you? _____

Name: _____ Home Phone: (____) _____ Social Security #: _____ - _____ - _____
 Cell Phone: (____) _____ Work Phone: (____) _____ Birth date: _____ Age: _____ Sex: Male Female
 Address: _____ Marital Status: Married Separated Widowed Divorced Single
 City: _____ State: _____ Zip: _____ Email: _____
 Patient Occupation: _____ Patient Employer/School: _____
 Employer/School Address: _____ Employer/School Phone: (____) _____
 Spouse's Name: _____ Work Phone: (____) _____ Spouse's Social Security #: _____ - _____ - _____
 Spouse's Occupation: _____ Spouse's Employer/School: _____
 Spouse's Birth date: _____ Spouse's Age: _____ Patient Employer/School: _____
 In case of emergency who should be notified? _____ Phone: (____) _____ Alt Phone: (____) _____

Dental Insurance Information

Insurance Company Name: _____ Group #: _____
 Who is the subscriber for this account? _____ What is their relationship to the patient? _____
 What is the subscriber's birth date? _____
 Is the patient covered by additional insurance? Yes No
 Insurance Company Name: _____ Group #: _____
 Who is the subscriber for this account? _____ What is their relationship to the patient? _____
 What is the subscriber's birth date? _____

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with _____ (name of insurance company) and assign directly to **Bob Pajoochi DMD PC / Congress Dental Group** 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 authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 (signature of patient, parent, guardian or personal representative) _____ (relationship to patient)

 (printed name of patient, parent, guardian or personal representative) _____ (date)

Today's Visit

What is the reason for today's visit? _____
 What are your present dental concerns? _____
 Who was your previous dentist? _____ City: _____ State: _____
 When was your last dental visit? _____ last dental x-rays? _____ last dental cleaning? _____
 Have you avoided regular dental care in the past? If so, why? _____
 What are your dental expectations? _____
 How would you rate your previous overall experiences with dental care? Positive Neutral Negative
 How often do you brush? _____ How often do you floss? _____
 Do you use any other cleaning aid? How often? _____
 Are you happy with the appearance of your teeth? Yes No Are you happy with the appearance of your gums? Yes No
 Would you like your teeth to be whiter? Yes No Would you like your teeth to be straighter? Yes No

Dental History

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

Active decay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen or tender gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth sores or growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal (gum) treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation on tongue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Broken fillings	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping jaw	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain from brushing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around the ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one side of mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gum disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe, or cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Foreign Objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Health History

Who is your current physician? _____ Date of last visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally		Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen feet or ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor	
Congenital heart lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent or bloody cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? Yes No

Is there anything else we should know? _____

WOMEN - Are you pregnant? Yes No Due date: _____ Are you nursing? Yes No Are you taking birth control pills? Yes No

Medications

List any medications you are currently taking and the correlating diagnosis. (If none, please write "none.") _____

Allergies

Aspirin	Iodine	Penicillin
Barbiturates (sleeping pills)	Latex	Sulfa
Codeine	Local anesthetic	
Other? (If none, please write "none.") _____		

By my signature below, I certify that I have read each of the above questions and that all of the information herein is correct to the best of my knowledge. I hereby certify that I have answered each of these questions truthfully, accurately and as completely as possible.

(signature of patient, parent, guardian or personal representative)

(relationship to patient)

(printed name of patient, parent, guardian or personal representative)

(date)