Ali Shirani, D.D.S.

3725 Lone Tree Way, Suite F
Antioch, California 94509

PATIENT INFORMATION

Date _____ Name (Last, First, Middle Initial) _____

Social Security # _____ Cell # _____ Home # _____

Address _____ City _____ State _____ Zip Code _____

Sex M ○ F ○ Age _____ Birthdate _____ Single ○ Married ○ Widowed ○ Divorced ○

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____ E-mail _____

In case of an emergency, whom should we notify? _____ Phone _____

PRIMARY INSURANCE

Person responsible for account _____ Birthdate _____

Relationship to patient _____ Social Security # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Person responsible employed by _____ Occupation _____

Business address _____ Phone _____

Insurance company _____

Contract# _____ Group# _____ Subscriber# _____

Other dependents covered on plan _____

SECONDARY INSURANCE

Is the patient covered by additional insurance? Yes ○ No ○

Subscriber Name _____ Relationship to patient _____

Social Security # _____ Birthdate _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Subscriber employed by _____ Occupation _____

Business address _____ Phone _____

Insurance company _____

Contract# _____ Group# _____ Subscriber# _____

Other dependents covered on plan _____

AUTHORIZATION

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorized the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of my benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

MEDICAL HISTORY

Personal Physician's Name _____

Phone _____

Current Physical Health Is: Good ○ Fair ○ Poor ○

Are you currently in the care of a personal physician? ○Y ○N

Please explain _____

Do you use tobacco in any form? ○Y ○N

Have you had any metal rods, pins of implants? ○Y ○N

Are you taking any prescription/over the counter drugs? ○Y ○N

Please list _____

Have you ever taken phen-fen, also called redux or pondimin? ○Y ○N

If so, when? _____

Have you ever had any of the following disease or medical problems?

○Y ○N Abnormal Bleeding	○Y ○N Hepatitis
○Y ○N AIDS	○Y ○N Herpes/Fever Blisters
○Y ○N Alcohol/Drug Abuse	○Y ○N High Blood Pressure
○Y ○N Anemia	○Y ○N HIV
○Y ○N Arthritis	○Y ○N Hospitalization
○Y ○N Artificial Bones/Joints/Valves	○Y ○N Kidney Problems
○Y ○N Asthma	○Y ○N Liver Disease
○Y ○N Blood Transfusion	○Y ○N Low Blood Pressure
○Y ○N Cancer/Chemotherapy	○Y ○N Mitral Valve Problems
○Y ○N Colitis	○Y ○N Pacemaker
○Y ○N Congenital Heart Defect	○Y ○N Psychiatric Problems
○Y ○N Diabetes	○Y ○N Radiation Treatment
○Y ○N Difficulty Breathing	○Y ○N Rheumatic/Scarlet Fever
○Y ○N Emphysema	○Y ○N Seizures
○Y ○N Epilepsy	○Y ○N Shingles
○Y ○N Fainting Spells	○Y ○N Sickle Cell disease
○Y ○N Frequent Headaches	○Y ○N Sinus Problems
○Y ○N Glaucoma	○Y ○N Stroke
○Y ○N Hay Fever	○Y ○N Thyroid Problems
○Y ○N Heart Attack/Surgery	○Y ○N Tuberculosis (TB)
○Y ○N Heart Murmur	○Y ○N Ulcers
○Y ○N Hemophilia	○Y ○N Venereal Disease
○Y ○N Fosomax/Bisphosphonates	

Please list any serious medical condition(s) you may have had:

_____

_____

Are you allergic to any of the following?

○Y ○N Aspirin	○Y ○N Latex
○Y ○N Codeine	○Y ○N Penicillin
○Y ○N Dental Anesthetics	○Y ○N Tetracycline
○Y ○N Erythromycin	○Y ○N Other
○Y ○N Jewlry/Metals	

Please list any other medications you are allergic to:

_____

Women

Are you taking birth control pills? ○Y ○N

Are you pregnant? Week# _____ ○Y ○N

Are you nursing? ○Y ○N

DENTAL HISTORY

Why Have You Come To The Dentist Today?

_____

Previous Dentist _____

Phone _____ Date Of Last Visit _____

Reason For Change _____

Current Dental Health Is: Good ○ Fair ○ Poor ○

Are you currently in pain? ○Y ○N

Do you require antibiotics before dental treatment? ○Y ○N

Have you ever had a problem with any previous dental work? ○Y ○N

Do you floss daily? ○Y ○N

Type of bristles on toothbrush? Hard ○ Med ○ Soft ○

Have you ever had gum treatment? ○Y ○N

Do your gums ever bleed? ○Y ○N

Have you ever had periodontal disease? ○Y ○N

Have you ever had pain/discomfort in your jaw joint? ○Y ○N

TMJ/TMD

Do you have mobility in your teeth? ○Y ○N

Are you sensitive to: Heat ○ Cold ○ Sweet ○ Other ○

Are you happy with the way your smile looks? ○Y ○N

If not, what would you change?

_____

I have received the dental materials sheet.

Initials _____ Date _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the office staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

Signature _____

Date _____

○ OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials _____ Date _____

Doctors Comments: _____

_____

_____

Medical History Update

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

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