**WELCOME. Please complete *ALL* fields below or we may not be able to treat you!**
**If not applicable, please mark with a "---".**

Date:____/____/____

Name:________________________________________ I prefer to be called:____________ [ ]Male [ ]Female

DOB:____/____/_____ Age:____ [ ]single [ ]married [ ]child SS#:______-_____-______ email:______________________________

Address:______________street______________________city______________________state____________zip__________

Tel:(_____)_____-______ Cell:(_____)_____-______ Work:(_____)_____-_____x______ Best Time/Place To Reach:____________________

Whom may we thank for referring you?__________________________ Other Family Members Seen by Us:__________________________

Driver's License #:_______-_______-______-_______ Employer:______________________ How long there?________ Occupation:_______________

Employer's Address:___________street______________________city______________________state____________zip__________

**Neighbor or Relative Not Living With You**

Name:__________________________ Relation:___________ Tel:(_____)_____-______ Cell:(_____)_____-______ Work:(_____)_____-_____x______

Address:______________street______________________city______________________state____________zip__________

**Person Responsible for Account if Other than Yourself**

Name:____________________________________________ Relation:___________ SS#:______-_____-______ DL#:______-______-_____-______

Billing Address:______________street______________________city______________________state____________zip__________

Tel:(____)____-______ Cell:(____)____-______ Work:(____)____-_____x_____ Employer:______________________________

**Spouse Information**

Name:____________________________________________ DOB:____/____/_____ SS #:______-____-______ DL#:______-______-______-______

Tel:(____)____-______ Cell:(____)____-______ Work:(____)____-_____x_____ Employer:______________________________

**Insurance Information**

Insured's Name:________________________________ Dental Coverage? **[ Y ] [ N ]** Medical Coverage? **[ Y ] [ N ]** Orthodontic Coverage? **[ Y ] [ N ]**

SS#:______-_____-______ DOB:____/____/____ Relation:__________________________ Insured's Employer:______________________

Employer's Address:___________street______________________city______________________state____________zip__________

Carrier Name:___________________ Tel:(_____)_____-_______ Group# (Plan, Local, or Policy#):______________________________

Address:______________street______________________city______________________state____________zip__________

**Secondary Insurance (If Applicable)**

Insured's Name:________________________________ Dental Coverage? **[ Y ] [ N ]** Medical Coverage? **[ Y ] [ N ]** Orthodontic Coverage? **[ Y ] [ N ]**

SS#:______-_____-______ DOB:____/____/____ Relation:__________________________ Insured's Employer:______________________

Employer's Address:___________street______________________city______________________state____________zip__________

Carrier Name:___________________ Tel:(_____)_____-_______ Group# (Plan, Local, or Policy#):______________________________

Address:______________street______________________city______________________state____________zip__________

## Dental History

Why have you come to the dentist today? ______________________________

______________________________________________________________

Are you currently in pain? [ Y ] [ N ]
Do you require antibiotics before dental treatment? [ Y ] [ N ]
Have you experienced problems associated with any previous dental work? [ Y ] [ N ]
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? [ Y ] [ N ]
Your current dental health is: **[ ]Good [ ]Fair [ ]Bad**
Do you floss daily? [ Y ] [ N ] Brush Daily? [ Y ] [ N ]
Type of bristles on your toothbrush? **[ ]Hard [ ]Med [ ]Soft**

How long do you use a toothbrush before replacing it?______________
Do you use anything in addition to your brush and floss? [ Y ] [ N ]

If yes, what? ______________________________________________
Would you like fresher breath? [ Y ] [ N ] Whiter teeth? [ Y ] [ N ]
Do your gums ever bleed? [ Y ] [ N ] Ever itch? [ Y ] [ N ]

Have you ever had periodontal disease? [ Y ] [ N ]
Do you have mobility in your teeth? [ Y ] [ N ]

Are your teeth sensitive to hot, cold, or anything else?______________________
Do you still have wisdom teeth? [ Y ] [ N ]

If yes, why?______________________________________________________

Previous / Present dentist:_________________ last visit:____/____/____
(Please circle one)

Why did you leave your previous dentist?__________________________________

What did you like most and least about any dentist you have seen?______________

______________________________________________________________

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

If not, what would you change?______________________________________

______________________________________________________________

## Medical History

Do you have a personal physician? [ Y ] [ N ]

Physician's Name:_________________________________________

Address:______________________________________________

______________________________________________

Tel:(_____)_____-_______ last visit:____/____/____
Your current physical health is [ ]Good [ ]Fair [ ]Poor
Are you currently under the care of a physician? [ Y ] [ N ]

Please explain:______________________________________________
Do you smoke or use tobacco in any other form? [ Y ] [ N ]
**Have you ever taken Fosamax, or any other Biphosphonate? [ Y ] [ N ]**

### Are you allergic to any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Aspirin | [ Y ] [ N ] | Erythromycin | [ Y ] [ N ] | Sedatives | [ Y ] [ N ] |
| Barbiturates | [ Y ] [ N ] | Jewelry/Metals | [ Y ] [ N ] | Sulfa Drugs | [ Y ] [ N ] |
| Codeine | [ Y ] [ N ] | Latex | [ Y ] [ N ] | Tetracycline | [ Y ] [ N ] |
| Dental Anesthetics | [ Y ] [ N ] | Penicillin | [ Y ] [ N ] | Other | [ Y ] [ N ] |

Please list any other drugs/materials that cause allergic reactions:__________

______________________________________________________________

For women: Are you taking birth control pills? [ Y ] [ N ]
Are you pregnant? **[ ]Unsure** [ Y ] [ N ]

Week#:____________ Are you nursing? [ Y ] [ N ]

### Are you taking any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Acetaminophen | [ Y ] [ N ] | Blood Thinners | [ Y ] [ N ] | Insulin/Diabetes Drugs | [ Y ] [ N ] | Thyroid Medicine | [ Y ] [ N ] |
| Antibiotics | [ Y ] [ N ] | Blood Pressure Medication | [ Y ] [ N ] | Nitroglycerin | [ Y ] [ N ] | Tranquilizers | [ Y ] [ N ] |
| Antihistamines | [ Y ] [ N ] | Cold Remedies | [ Y ] [ N ] | Recreational Drugs | [ Y ] [ N ] | Have you ever taken Phen-Fen (also Known as Redux or Pondimin)? | [ Y ] [ N ] |
| Aspirin | [ Y ] [ N ] | Digitalis/Heart Medication | [ Y ] [ N ] | Steroids/Cortisone | [ Y ] [ N ] | | |

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins, or minerals not listed? [ Y ] [ N ] If yes, please list each one with **dosage and frequency**:______________________________________________

______________________________________________________________

### Do you or have you experienced the following?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Abnormal Bleeding | [ Y ] [ N ] | Colitis | [ Y ] [ N ] | Headaches | [ Y ] [ N ] | Liver Disease | [ Y ] [ N ] | Seizures | [ Y ] [ N ] |
| Alcohol Abuse | [ Y ] [ N ] | Congenital Heart Defect | [ Y ] [ N ] | Heart Attack | [ Y ] [ N ] | Low Blood Pressure | [ Y ] [ N ] | Shingles | [ Y ] [ N ] |
| Anemia | [ Y ] [ N ] | Diabetes | [ Y ] [ N ] | Heart Murmur | [ Y ] [ N ] | Lupus | [ Y ] [ N ] | Sickle Cell Disease | [ Y ] [ N ] |
| Arthritis | [ Y ] [ N ] | Difficulty Breathing | [ Y ] [ N ] | Heart Surgery | [ Y ] [ N ] | Mitral Valve Prolapse | [ Y ] [ N ] | Sinus Problems | [ Y ] [ N ] |
| Artificial Bones/Joints | [ Y ] [ N ] | Drug Abuse | [ Y ] [ N ] | Hemophilia | [ Y ] [ N ] | Osteporosis/Paget's Disease | [ Y ] [ N ] | Steroid Therapy | [ Y ] [ N ] |
| Artificial Valves | [ Y ] [ N ] | Emphysema | [ Y ] [ N ] | Hepatitis | [ Y ] [ N ] | Pacemaker | [ Y ] [ N ] | Stroke | [ Y ] [ N ] |
| Asthma | [ Y ] [ N ] | Epilepsy | [ Y ] [ N ] | Herpes | [ Y ] [ N ] | Persistent Cough | [ Y ] [ N ] | Thyroid Problems | [ Y ] [ N ] |
| Blood Transfusion | [ Y ] [ N ] | Fainting Spells | [ Y ] [ N ] | High Blood Pressure | [ Y ] [ N ] | Psychiatric Problems | [ Y ] [ N ] | Tonsillitis | [ Y ] [ N ] |
| Cancer | [ Y ] [ N ] | Fever Blisters | [ Y ] [ N ] | HIV+/AIDS | [ Y ] [ N ] | Radiation Treatment | [ Y ] [ N ] | Tuberculosis (TB) | [ Y ] [ N ] |
| Chemotherapy | [ Y ] [ N ] | Glaucoma | [ Y ] [ N ] | Hospitalized for Any Reason | [ Y ] [ N ] | Rheumatic Fever | [ Y ] [ N ] | Ulcers | [ Y ] [ N ] |
| Chicken Pox | [ Y ] [ N ] | Hay Fever | [ Y ] [ N ] | Kidney Problems | [ Y ] [ N ] | Scarlet Fever | [ Y ] [ N ] | Venereal Disease | [ Y ] [ N ] |

Please list any serious medical condition(s) that you may have experienced: ______________________________________

______________________________________________________________

## AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It 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 dental staff to perform the necessary dental services I may need. My method of payment will be ____________________.

______________________________________________
Signature Date

### PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I certify that I am covered by ______________________________ Insurance Co. and I assign directly to Dr. Amayun all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

______________________________________________
Signature Date