



Scident Family Dental Clinic



Dr. Babak Chehroudi, D.M.D., Ph.D.
&
Associates

Medical Alert:

File Number: _____

Personal Information and Patient Registration

"All information is strictly confidential"

LAST NAME		FIRST	MIDDLE	DATE OF BIRTH	
				Y	/M /D
ADDRESS					
CITY/PROVINCE				POSTAL CODE	
TELEPHONE RESIDENCE:		BUSINESS:		MESSAGES:	
OCCUPATION			EMPLOYER		
HOW DID YOU HEAR ABOUT THE OFFICE: (Referral Source)			E-Mail:		
PERSON RESPONSIBLE FOR THE ACCOUNT IF DIFFERENT FROM ABOVE				DO YOU HAVE DENTAL INSURANCE	
Name:		Relationship:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
ADDRESS IF DIFFERENT FROM ABOVE				IN CASE OF EMERGENCY, PLEASE NOTIFY	
EMPLOYER				Name:	
				Relationship:	
				Telephone:	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT OF OUR OFFICE?				YES <input type="checkbox"/> NO <input type="checkbox"/>	
RELATIONSHIP:					

Dental Insurance Status

Insurance Company #1.....
Policy Holder.....Employer.....
Grp/Policy:.....ID/Cert:.....
Coverage: Preventive:..... Basic:..... Major:.....
Ortho:..... Scl/Rtpl:..... Endo:..... Surgical:.....
Limits: Basic:..... Major:..... Combined:.....
Benefit Year:....., Deductable:.....
Recall Frequency:
Scl:..... Rtpl:..... OHI:.....
Radiographs: Pan:..... FMS:..... BW:.....
Exams: Spec:..... Emerg:..... Complete:.....
Composite Flgs: Molars:..... Premolars:.....
Night Guard: Basic:..... Major:..... pre-auth:.....
Claim Submission: Paper Y - N Electronic(EDI) Y - N
Assignment Allowed: Y....., N.....

Insurance Company #2.....
Policy Holder.....Employer.....
Grp/Policy:.....ID/Cert:.....
Coverage: Preventive:..... Basic:..... Major:.....
Ortho:..... Scl/Rtpl:..... Endo:..... Surgical:.....
Limits: Basic:..... Major:..... Combined:.....
Benefit Year:....., Deductable:.....
Recall Frequency:
Scl:..... Rtpl:..... OHI:.....
Radiographs: Pan:..... FMS:..... BW:.....
Exams: Spec:..... Emerg:..... Complete:.....
Composite Flgs: Molars:..... Premolars:.....
Night Guard: Basic:..... Major:..... pre-auth:.....
Claim Submission: Paper Y - N Electronic(EDI) Y - N
Assignment Allowed: Y....., N.....

MEDICAL HISTORY

MEDICAL ALERT: _____ _____ _____ _____
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NAME: _____

1. Has there been any change in your general health within the last year? Yes No
2. Are you presently under the care of a physician? If so, for what condition? Yes No

3. The name and address of your physician is: _____

4. My last physical exam was on....., and in that examination was anything unusual or abnormal found? _____

5. Have you ever been hospitalized or had serious illness? If yes what was the problem? .. Yes No

6. Have you ever required a blood transfusion, If yes, what were the circumstances Yes No

7. Are you taking any medicine, drugs, or pills of any kind? If yes, What kind? Yes No

8. Do you have any allergies? If yes, to what and how do you react? Yes No

9. Have you ever had an unusual reaction to a dental anesthesia? Yes No

10. Have you ever had abnormal bleeding associated with surgery, injuries, or extractions? Yes No

11. Have you ever had any known contact with the AIDS virus? Yes No
12. Has any member of your family had diabetes? Yes No
13. Have you ever fainted Yes No

14. Are you pregnant? If so which month are you in? _____ Yes No
15. Are you taking any birth control pills? Yes No
16. Are you breast feeding? Yes No

17. Do you have or have you ever had any of the following disorders? [Please check]
- | | |
|---|--|
| Rheumatic heart disease..... <input type="checkbox"/> | Stomach/intestine problems..... <input type="checkbox"/> |
| Rheumatic fever..... <input type="checkbox"/> | Tuberculosis..... <input type="checkbox"/> |
| Congenital heart disease..... <input type="checkbox"/> | Asthma..... <input type="checkbox"/> |
| Coronary artery angina..... <input type="checkbox"/> | Lung disease..... <input type="checkbox"/> |
| Heart attack..... <input type="checkbox"/> | Venereal disease..... <input type="checkbox"/> |
| Stroke..... <input type="checkbox"/> | Positive testing for HIV virus..... <input type="checkbox"/> |
| High blood pressure..... <input type="checkbox"/> | Blood disorder..... <input type="checkbox"/> |
| Heart murmur..... <input type="checkbox"/> | Hepatitis A/B..... <input type="checkbox"/> |
| Diabetes (sugar disease)..... <input type="checkbox"/> | Epilepsy or seizures..... <input type="checkbox"/> |
| Kidney disease..... <input type="checkbox"/> | Sinus trouble..... <input type="checkbox"/> |
| Liver disease..... <input type="checkbox"/> | Drug addiction..... <input type="checkbox"/> |
| Thyroid disease..... <input type="checkbox"/> | Mental or nervous disorders..... <input type="checkbox"/> |
| Cortisone/steroid therapy..... <input type="checkbox"/> | Herpes/cold sores..... <input type="checkbox"/> |
| Severe headaches..... <input type="checkbox"/> | Cancer..... <input type="checkbox"/> |
| Dizziness or fainting..... <input type="checkbox"/> | Ear problem..... <input type="checkbox"/> |
| Bruise easily..... <input type="checkbox"/> | Eye problem..... <input type="checkbox"/> |
| Sore throat..... <input type="checkbox"/> | Nose bleeds..... <input type="checkbox"/> |
| Frequent colds..... <input type="checkbox"/> | Chest pain on exertion..... <input type="checkbox"/> |
| Swollen ankles..... <input type="checkbox"/> | Speech problem..... <input type="checkbox"/> |
| Shortness of breath..... <input type="checkbox"/> | Others..... <input type="checkbox"/> |

18. Have you ever had radiation treatment or chemotherapy?..... Yes No
19. Have you had organ transplants or medical implants?..... Yes No
20. Do you consider yourself a healthy individual..... Yes No
21. Is there any disease or problem not listed above?..... Yes No
22. Vital signs Blood Pressure _____ Pulse _____ Respiration _____ Temperature _____

DENTAL HISTORY

1. Chief dental complaint _____
2. Reason for today's appointment: Consult Exam Cleaning Emergency Others
3. How often do you see a dentist? _____ Date of last visit _____ Reason _____
4. Name of your former dentist _____ Telephone: _____
5. Date of last cleaning _____ Date of last full mouth x-ray _____

Dental Hygiene

5. Have you ever had proper oral hygiene instruction Yes No
6. Do you brush? Yes No How often? 1Xday 2Xday 3Xday 2Xweek .. Other _____
7. What kind of brush do you use? Soft Medium Hard Others _____
8. Do you floss? Yes No How often? 1Xday 2Xday 3Xday 2Xweek Other _____
9. What kind of floss do you use? Waxed Unwaxed Tape Others _____
10. Does your gum bleed, when you Brush Floss Spontaneous

Teeth and Occlusion

11. Is/Are your tooth/teeth sensitive to Cold Heat Sweets Others _____
12. Do you chew on one side of your mouth Yes No Right side Left side
13. Are you aware of grinding your teeth at night or day time Yes No
14. Does your jaw click or crack or pop when you chew or open widely? Yes No

15. Please check (✓), if you now have or ever had any of the following conditions/treatments in your mouth:

- | | | | | | |
|-------------------------|--------------------------|---------------------|--------------------------|-----------------------|--------------------------|
| Broken or lost fillings | <input type="checkbox"/> | Root canal fillings | <input type="checkbox"/> | Partial dentures | <input type="checkbox"/> |
| Extraction | <input type="checkbox"/> | Gum Surgery | <input type="checkbox"/> | Complete dentures | <input type="checkbox"/> |
| Loose teeth | <input type="checkbox"/> | Bridges | <input type="checkbox"/> | Dental implants | <input type="checkbox"/> |
| Swelling | <input type="checkbox"/> | Crowns/Caps | <input type="checkbox"/> | Orthodontic treatment | <input type="checkbox"/> |
| Bad Breath | <input type="checkbox"/> | Bleeding from gum | <input type="checkbox"/> | Bleaching | <input type="checkbox"/> |

16. How would you rate your current oral health: Excellent Good Fair Poor

Treatment Authorization & Consent

I, the undersigned, certify that all information provided in this chart is true and I have not deliberately withheld any information, if it is necessary for my dental health, I authorize the dentist to contact my physician for confirming the medical information. I also consent to the dental treatments including surgical procedures agreed to be necessary or beneficial for my dental condition and will assume responsibility for fees associated with these procedures.

Patient [Parents, Guardian] Signature _____

Date _____

To avoid complications, it is important to inform the office of any changes in your medical conditions.