Valley Fair Family and Cosmetic Dentistry

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As a patient of Dr. Ghazanfari's you authorize us to claim your insurance. Any remaining balance is the patients responsibility.

1 About You

Today's Date: ....

Name: ....
LAST FIRST MI MR MRS MS DR

I prefer to be called: .... ☐ Male ☐ Female

Birthdate: ..../......../............... Age: .... SS#: ....

Home Address: ....
APT/ CONDO #

....
CITY STATE ZIP

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home#: .... Pager/Other#: ....

WK#: .... Ext: .... DL#: ....

Employer: ....

Employer's Address: ....

How long there? .... Occupation: ....

Where & when are best times to reach you? ....

Who may we Thank for referring you? ....

Other family members seen by us: ....

Previous/Present Dentist: ....
(Please Circle)

Last Visit Date: ....

3 Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ....

Insurance Co. Address: ....

Insurance Co. Phone#: ....

Group # (Plan, Local or Policy #): ....

Insured's Name: .... Relation: ....

Insured's Birthday: ..../......../........ Insured's SS#: ....

Insured's Employer: ....

Secondary Dental Insurance

Insurance Co. Name: ....

Insurance Co. Address: ....

Insurance Co. Phone#: ....

Group # (Plan, Local or Policy #): ....

Insured's Name: .... Relation: ....

Insured's Birthday: ..../......../........ Insured's SS#: ....

Insured's Employer: ....

2 Spouse Information

Their Name: ....

Employer: ....

WK#: .... Ext: .... SS#: ....

Birthdate: ..../......../............... DL#: ....

In the event of an emergency, Is there someone who lives near you that we should contact?

Their Name: .... Relation: ....

WK#: .... HM#: ....

Person Responsible for Account: ....

WK#: .... Ext: .... HM#: ....

Billing Address: ....

Relationship: .... SS#: ....

Employer: .... DL#: ....

4 Medical History

Do you have a personal physician? ☐ No ☐ Yes

Physician's Name: ....

Phone#: .... Date of last visit: ....

CONTINUED ON BACK OF FORM

4 MEDICAL HISTORY CONTINUED

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ No ☐ Yes

Please explain: ....

Are you taking any prescription/over the counter drug? ☐ No ☐ Yes

Please list each one: ....

For Women, Are you taking birth control pills? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes Week#: ....

Are you nursing? ☐ No ☐ Yes

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

Y N Hear Attack / Stroke	Y N Psychiatric Problems
Y N Cancer / Chemotherapy	Y N Epilepsy / Seizures / Spells
Y N Heart Murmur	Y N Diabetes / Tuberculosis
Y N Pneumatic Fever	Y N Drug / Alcohol Abuse
Y N HIV - / AIDS	Y N Venereal Disease
Y N Heart Surgery / Pacemaker	Y N Hemophilia / Abnormal Bleeding
Y N Shingles	Y N Ulcers / Coilis?
Y N Mitral Valve Prolapse	Y N Congenital Heart Defect
Y N Kidney Problems	Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints	Y N Asthma / Arthritis
Y N Artificial Valves	Y N Difficulty Breathing
Y N Sinus Problems	Y N Hospitalized for Any Reason
Y N High / Low Blood Pressure	Y N Hepatitis
Y N Fever Blisters	Y N Blood Transfusion
Y N Severe, Frequent Headaches	Y N Emphysema / Glaucoma

Please list any serious medical condition(s) that you've ever had:

....

....

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other drugs that you are allergic to: ....

....

5 DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? ☐ No ☐ Yes

....

....

Have you ever had a serious / difficult problem associated with any pervious dental work? ☐ No ☐ Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ No ☐ Yes

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ No ☐ Yes

Do your gums every bleed? ☐ No ☐ Yes

How many times a week do you floss? ..... a day you brush? ......

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

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 dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

....

Signature Date

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

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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

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I verbally reviewed the medical / dental information above with the patient names herein. Initials __________ Date: __________

Doctor's Comments: ____

____

MEDICAL HISTORY UPDATE

1. Date __________ Comments __________ Signature __________
2. Date __________ Comments __________ Signature __________
3. Date __________ Comments __________ Signature __________