

welcome

PATIENT NUMBER

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Last First Initial

If Child: Parent's Name \_\_\_\_\_

How do you wish to be addressed \_\_\_\_\_  
Single  Married  Separated  Divorced  Widowed  Minor

Residence - Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Business Address \_\_\_\_\_

Telephone: Res. \_\_\_\_\_ Bus. \_\_\_\_\_

Fax \_\_\_\_\_ Cell Phone # \_\_\_\_\_

eMail \_\_\_\_\_

Patient/Parent Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Spouse Employed By \_\_\_\_\_

Present Position \_\_\_\_\_

How Long Held \_\_\_\_\_

Who is Responsible for this account \_\_\_\_\_

Drivers License No. \_\_\_\_\_

Method of Payment: Insurance  Cash  Credit Card

Purpose of Call \_\_\_\_\_

Other Family Members in this Practice \_\_\_\_\_

Whom may we thank for this referral \_\_\_\_\_

Patient/parent Social Security No. \_\_\_\_\_

Spouse/Parent Social Security No. \_\_\_\_\_

Someone to notify in case of emergency not living with you \_\_\_\_\_

**DENTAL INSURANCE  
1ST COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**DENTAL INSURANCE  
2ND COVERAGE**

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Employer Name \_\_\_\_\_ Yrs. \_\_\_\_\_

Name of Insurance Co. \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Program or policy # \_\_\_\_\_

Social Security No. \_\_\_\_\_

Union Local or Group \_\_\_\_\_

**CONSENT:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I attest to the accuracy of the information on this page.

PATIENT'S OR GUARDIAN'S SIGNATURE

DATE \_\_\_\_\_

welcome

PATIENT NUMBER

Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth \_\_\_\_\_

CIRCLE THE APPROPRIATE ANSWER, IF YOU DON'T KNOW THE CORRECT ANSWER PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION

COMMENTS

- 1. Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel: ( \_\_\_\_\_ )
2. Are you under a physician's care? ... YES NO
3. When was your last complete physical exam?
4. Are you taking any medication or substances? ... YES NO
5. Do you routinely take health related substances? ... YES NO
6. Are you allergic to any medications or substances? (please list) ... YES NO
7. Do you have any other allergies or hives? ... YES NO
8. Do you have any problems with penicillin, antibiotics, anesthetics or other medications? ... YES NO
9. Are you sensitive to any metals or latex? ... YES NO
10. Are you pregnant or suspect you may be? ... YES NO
11. Do you use any birth control medications? ... YES NO
12. Have you ever been treated for or been told you might have heart disease? ... YES NO
13. Do you have a pacemaker or an artificial heart valve implant? ... YES NO
14. Have you ever had rheumatic fever? ... YES NO
15. Are you aware of any heart murmurs? ... YES NO
16. Do you have high or low blood pressure? (please circle) ... YES NO
17. Have you ever had a serious illness or major surgery? ... YES NO
18. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ... YES NO
19. Do you have inflammatory diseases, such as arthritis or rheumatism? ... YES NO
20. Do you have any artificial joints/prosthesis? ... YES NO
21. Do you have any blood disorders, such as anemia, leukemia, etc? ... YES NO
22. Have you ever bled excessively after being cut or injured? ... YES NO
23. Do you have any stomach problems? ... YES NO
24. Do you have any kidney problems? ... YES NO
25. Do you have any liver problems? ... YES NO
26. Are you diabetic? ... YES NO
27. Do you have fainting or dizzy spells? ... YES NO
28. Do you have asthma? ... YES NO
29. Do you have epilepsy or seizure disorders? ... YES NO
30. Do you or have you had venereal disease? ... YES NO
31. Have you tested HIV positive? ... YES NO
32. Do you have AIDS? ... YES NO
33. Have you had or do you test positive for hepatitis? ... YES NO
34. Do you or have you had T.B.? ... YES NO
35. Do you smoke, chew, use snuff or any other forms of tobacco? ... YES NO
36. Do you consume alcoholic beverages? ... YES NO
37. Do you habitually use controlled substances? ... YES NO
38. Have you had psychiatric treatment? ... YES NO
39. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen), dexfenfluramine (redux), or other weight loss products? ... YES NO
40. Do you have any disease condition, or problem not listed? If so, explain
41. Is there anything else we should know about your health that we have not covered in this form?
42. Would you like to speak to the Doctor privately about any problem? ... YES NO

Large empty box for patient comments with a small text prompt: 'Any changes in your medical history since your last visit. [ ] No [ ] Yes Explain'

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE
PATIENT'S / GUARDIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_
DENTIST'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

ANEST. box

MED. ALERT box

MEDICAL HISTORY

REORDER OBS 800-634-1876 LECLECMH113BLUE

welcome

Patient Number grid

PATIENT NUMBER

Patient's Name Last First Initial Date of Birth

- 1. Purpose of initial visit
2. Are you aware of a problem?
3. How long since your last dental visit?
4. What was done at that time?
5. Previous dentist's name
6. When was the last time your teeth were cleaned?

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

- 7. Have you made regular visits? YES NO
8. Were dental x-rays taken? YES NO
9. Have you lost any teeth or have any teeth been removed? YES NO
10. Have they been replaced? YES NO
11. How have they been replaced?
12. Are you unhappy with the replacement? YES NO
13. Would you like to know about permanent replacements? YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO
15. Do you clench or grind your teeth? YES NO
16. Does your jaw click or pop? YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
21. Do your gums bleed or hurt? YES NO
22. How often do you brush your teeth? When?
23. Do you use dental floss? YES NO
24. Are any of your teeth loose, tipped, shifted or chipped? YES NO
25. Are you unhappy with the appearance of your teeth? YES NO
26. How do you feel about your teeth in general?
27. Do you feel your breath is offensive at times? YES NO
28. Have you ever had gum treatment or surgery? YES NO
29. Have you had any orthodontic work?
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?
31. Do you have any questions or concerns? YES NO

COMMENTS

Large box for patient comments and medical history changes.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE DATE

DENTIST'S SIGNATURE DATE

ANEST. box

MED. ALERT box

DENTAL HISTORY

welcome

PATIENT NUMBER

Patient's Name Last First Initial Nickname Date of Birth
Parent's Guardian's Name

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

COMMENTS

- 1. Is this your child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist?
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. When does your child brush his/her teeth?
7. How does your child receive Fluoride?
8. Have any cavities been noted in the past? YES NO
9. Were any teeth (baby or permanent) removed by extraction? YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc? YES NO
11. Has your child had any problem with dental treatment in the past? YES NO
12. Has anyone in the family, including parents, had orthodontics? YES NO
13. Has your child ever received a local anesthetic? YES NO
14. Has your child ever had occlusal sealants? YES NO
15. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY

- 1. Does your child have a health problem? YES NO
2. Is your child under care of physician? YES NO
3. Name of physician Phone
4. Is your child receiving any medication? YES NO
5. Is your child allergic to penicillin, antibiotics or other drugs? YES NO
6. Is your child allergic to or sensitive to any metals or latex? YES NO
7. Does your child have other allergies? YES NO
8. Has your child had any serious illness? YES NO
9. Has your child ever had surgery? YES NO
10. Does your child have a heart murmur? YES NO
11. Is surgery contemplated? YES NO
12. Does your child experience severe or prolonged bleeding? YES NO
13. Does your child have AIDS or has he/she tested HIV positive? YES NO
14. Has your child tested positive for hepatitis? YES NO
15. Is your child subject to nervous disorders? YES NO
16. Does your child have frequent headaches? YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

Any changes in your medical history since your last visit. No Yes Explain

Blank lines for patient/guardian explanation of medical history changes.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE DATE
DENTIST'S SIGNATURE DATE

ANEST. box

MED. ALERT box

CHILD DENTAL MEDICAL HISTORY

REORDER OBS 800-634-1876 LECCOM11GREEN

**ALI BEHZADI, D.M.D.**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES  
WRITTEN ACKNOWLEDGEMENT FORM**

I, \_\_\_\_\_, have reviewed/received a copy of

Patient Name

**ALI BEHZADI, D.M.D.**

's Notice of Privacy Practices.

Practice Name

\_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_  
Date

---

**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
-------	-----------	---------

REORDER OBS 1-800-634-1876  
HIPAA04P

**NOTICE OF PRIVACY RECEIPT**