



M. Magsoudi, D.D.S., P.C. Family Dentistry



Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient's Sex ☐ F ☐ M

PATIENT INFORMATION

(CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/PC. _____

Email _____ Cell Phone _____

Do you prefer to receive calls at your: ☐ Home ☐ Work ☐ Cell Phone

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State/Prov. _____ Zip/PC. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License# _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/PC. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/PC. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/PC. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please



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Family Dentistry

PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now?.....	Yes	No	10. Are you wearing contact lenses?.....	Yes	No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	Yes	No	11. Are you allergic to or have you had any reactions to the following?.....	Yes	No
If yes, please explain _____			Local Anesthetics (e.g. Novocain).....	Yes	No
3. Are you taking any medication(s) including non-prescription medicine?	Yes	No	Penicillin or any other Antibiotics.....	Yes	No
If yes, what medication(s) are you taking?			Sulfa Drugs.....	Yes	No
4. Have you ever taken Fen-Phen/Redux?.....	Yes	No	Barbiturates.....	Yes	No
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	Yes	No	Sedatives.....	Yes	No
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?.....	Yes	No	Iodine.....	Yes	No
7. Do you use tobacco?.....	Yes	No	Aspirin.....	Yes	No
8. Do you use controlled substances?.....	Yes	No	Any Metals (e.g. nickel, mercury, etc.).....	Yes	No
9. Do you have or have you had any of the following?			Latex Rubber.....	Yes	No
High Blood Pressure.....	Yes	No	Other.....	Yes	No
Heart Attack.....	Yes	No	12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	Yes	No
Rheumatic Fever.....	Yes	No	13. Women Only:		
Swollen Ankles.....	Yes	No	a) Are you pregnant or think you may be pregnant?.....	Yes	No
Fainting / Seizures.....	Yes	No	b) Are you nursing?.....	Yes	No
Asthma.....	Yes	No	c) Are you taking oral contraceptives?.....	Yes	No
Low Blood Pressure.....	Yes	No			
Epilepsy / Convulsions.....	Yes	No			
Leukemia.....	Yes	No			
Diabetes.....	Yes	No			
Kidney Diseases.....	Yes	No			
AIDS or HIV Infection.....	Yes	No			
Thyroid Problem.....	Yes	No			
Heart Disease.....	Yes	No			
Cardiac Pacemaker.....	Yes	No			
Heart Murmur.....	Yes	No			
Angina.....	Yes	No			
Frequently Tired.....	Yes	No			
Anemia.....	Yes	No			
Emphysema.....	Yes	No			
Cancer.....	Yes	No			
Arthritis.....	Yes	No			
Joint Replacement or Implant.....	Yes	No			
Hepatitis / Jaundice.....	Yes	No			
Sexually Transmitted Disease.....	Yes	No			
Stomach Troubles / Ulcers.....	Yes	No			
Chest Pains.....	Yes	No			
Easily Winded.....	Yes	No			
Stroke.....	Yes	No			
Hay Fever / Allergies.....	Yes	No			
Tuberculosis.....	Yes	No			
Radiation Therapy.....	Yes	No			
Glaucoma.....	Yes	No			
Recent Weight Loss.....	Yes	No			
Liver Disease.....	Yes	No			
Heart Trouble.....	Yes	No			
Respiratory Problems.....	Yes	No			
Mitral Valve Prolapse.....	Yes	No			
Other.....	Yes	No			

PATIENT DENTAL HISTORY

Name of Previous Dentist and Location _____ Date of Last Exam _____

1. Do your gums bleed while brushing or flossing?.....	Yes	No	8. Do you have frequent headaches?.....	Yes	No
2. Are your teeth sensitive to hot or cold liquids/foods?.....	Yes	No	9. Do you clench or grind your teeth?.....	Yes	No
3. Are your teeth sensitive to sweet or sour liquids/foods?.....	Yes	No	10. Do you bite your lips or cheeks frequently?	Yes	No
4. Do you feel pain to any of your teeth?.....	Yes	No	11. Have you ever had any difficult extractions in the past?.....	Yes	No
5. Do you have any sores or lumps in or near your mouth?	Yes	No	12. Have you ever had any prolonged bleeding following extractions?.....	Yes	No
6. Have you had any head, neck or jaw injuries?.....	Yes	No	13. Have you had any orthodontic treatment?	Yes	No
7. Have you ever experienced any of the following problems in your jaw?	Yes	No	14. Do you wear dentures or partials?	Yes	No
Clicking.....	Yes	No	If yes, date of placement.....	Yes	No
Pain (joint, ear, side of face).....	Yes	No	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	Yes	No
Difficulty in opening or closing.....	Yes	No	16. Do you like your smile?	Yes	No
Difficulty in chewing.....	Yes	No			

AUTHORIZATION AND RELEASE

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

This office accepts insurance. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

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 that I may need during diagnosis and treatment, with my informed consent.

X

Signature of patient (or parent/guardian if minor)

Date