

Magsoudi, D.D.S.
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 INFORMATION (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ SS# _____ Home Phone _____
Address _____ City _____ State _____ ZIP _____ Cell Phone _____
Email _____
Do you prefer to receive calls at your ☐ Home ☐ Cell Phone
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____
☐ Minor ☐ Married ☐ Divorced ☐ Widowed

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ State _____ ZIP _____ Home Phone _____
Email _____ Cell Phone _____
Birthdate _____
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# _____ Date Employed _____
Name of Employer _____
Address of Employer _____ City _____ State _____ ZIP _____
Insurance Company _____ Group # _____ Policy/ID # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS# _____
Insurance Company _____ Group # _____ Policy/ID # _____

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PATIENT MEDICAL HISTORY

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain _____	☐	☐
3. Are you taking any medication(s) including non-prescription medicine ? If yes, what medication(s) are you taking? _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances ?	☐	☐

7 Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other _____		
8 Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐	☐
9 Women Only :		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing ?	☐	☐

6. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever / Allergies	☐	☐
Fainting / Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy / Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	If yes _____			Liver Disease	☐	☐
Diabetes	☐	☐	Arthritis	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Joint Replacement or Implant	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Hepatitis / Jaundice	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Sexually Transmitted Disease	☐	☐	Other _____	☐	☐
			Stomach Troubles / Ulcers					

PATIENT DENTAL HISTORY

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

	Yes	No
1. Do your gums bleed while brushing or flossing ?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods ?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods ?	☐	☐
4. Do you feel pain to any of your teeth ?	☐	☐
5. Do you have any sores or lumps in or near your mouth ?	☐	☐
6. Have you had any head, neck or jaw injuries ?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions ?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

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.

_____

Signature of patient (or parent/guardian if minor) *Date*