WELCOME TO OUR OFFICE

Royal Dental Practice

Roya Shoffet-Yaghoubian, D.M.D., D.D.S.
Family & Cosmetic Dentistry

TODAY'S DATE _____

REVISED DATE _____

REFERRED BY _____

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL. PLEASE PRINT CLEARLY.

PATIENT'S NAME_____ BIRTHDATE_____
(Last) (First) (Middle) (Nickname) (Month, Date, Year)

SOCIAL SECURITY # _____ MARITAL STATUS_____

ADDRESS_____
(Street) (City) (Zip Code)

HOME PHONE ( ) _____-_____ WORK PHONE ( ) _____-_____ CELL PHONE ( ) _____-_____
Area Code Area Code Area Code

EMAIL ADDRESS _____@_____ EMPLOYER _____

EMPLOYER'S ADDRESS _____
(Street) (City) (Zip Code)

NAME OF SPOUSE (OR PARENT) _____ ADDRESS_____

SOCIAL SECURITY # OF SPOUSE _____ PHONE ( ) _____-_____
Area Code

CHIEF COMPLAINT / REASON _____

DATE OF LAST GENERAL PHYSICAL EXAM _____
(Month - Year)

LIST ANY ALLERGIES YOU HAVE (DRUGS, FOOD, HAY FEVER, OTHER) _____

LIST ANY MEDICATIONS YOU ARE TAKING _____

DESCRIBE ANY CONDITIONS WE SHOULD KNOW ABOUT _____

DO YOU HAVE HIGH BLOOD PRESSURE? _____ DIABETES_____

PRIMARY INSURANCE COMPANY _____ POLICY # _____

SUBSCRIBER NAME _____ SOCIAL SECURITY # _____

DO YOU HAVE INSURANCE THROUGH YOUR EMPLOYER? _____ IF YES, I.D. # _____

GROUP # _____

ANY SECONDARY INSURANCE? _____ IF YES, COMPANY _____

ADDRESS TO SEND CLAIM _____

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME. INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS

Signed _____ Date _____
(Patient, or Parent if Minor)

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

Signed _____ Date _____

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PATIENT'S NAME _____ SS# _____ OCCUPATION _____

REASON FOR VISITING _____

PLEASE ANSWER ALL QUESTIONS BY MARKING YES OR NO. YOUR RESPONSE TO THIS QUESTIONNAIRE WILL BE HELD STRICTLY CONFIDENTIAL AND WILL ONLY BE USED TO ASSIST IN THE ASSESSMENT OF YOUR MEDICAL CONDITION. IF YOU HAVE ANY HESITATIONS PLEASE DISCUSS YOUR CONCERN WITH ONE OF THE FACULTY MEMBERS.

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Cardiovascular Disorders:

YES	NO	
□	□	High blood pressure
□	□	Congenital heart disease
□	□	Rheumatic fever
□	□	Heart murmur
□	□	Heart pacemaker
□	□	Vascular graft
□	□	Heart or bypass surgery
□	□	Artificial heart valve
□	□	Heart attack
□	□	Congestive heart failure
□	□	Awaken with breathing difficulty
□	□	Angina pectoris / chest pain
□	□	Swollen ankles
□	□	Irregular or rapid heart beats
□	□	Stroke

Respiratory Disorders:

YES	NO	
□	□	Emphysema or asthma
□	□	Hay fever
□	□	Chronic cough or bronchitis
□	□	Tuberculosis (TB)
□	□	Chronic sinusitis
□	□	Breathing problems

Musculo-Skeletal / CNS / Developmental Disorders:

YES	NO	
□	□	Frequent headaches
□	□	Fainting spells or loss of consciousness
□	□	Seizures or epilepsy
□	□	Visual impairment
□	□	Hearing impairment
□	□	Artificial joint
□	□	Arthritis or bone disease
□	□	Muscle disease
□	□	Spinal cord injury or paralysis
□	□	Cerebral palsy
□	□	Mental retardation / autism
□	□	Alzheimer's disease or other dementia

Gastrointestinal/Genitourinary Disorders:

YES	NO	
□	□	Colitis or ulcers
□	□	Hepatitis or other liver disease
□	□	Jaundice
□	□	Renal dialysis / transplant
□	□	Kidney disease
□	□	Syphilis, gonorrhea or other sexually transmitted diseases
□	□	Genital herpes
□	□	Frequent canker sores
□	□	Frequent cold sores
□	□	Chronic diarrhea
□	□	Frequent vomiting
□	□	History of Fen-Phen

Hematologic / Endocrine / Immune Disorders

YES	NO	
□	□	Blood transfusion
□	□	Denied permission to give blood
□	□	Anemia / leukemia / lymphoma
□	□	Hemophilia
□	□	Sickle cell disease
□	□	Blood clots or thrombosis
□	□	Diabetes
□	□	Thyroid disease
□	□	Adrenal gland disease
□	□	AIDS
□	□	HIV infection
□	□	Bleeding or bruising tendency
□	□	Sudden weight loss or gain
□	□	Frequent thirst
□	□	Frequent hunger
□	□	Frequent urination
□	□	Cancer / radiotherapy / chemotherapy
□	□	Systemic lupus

Psychiatric

YES	NO	
□	□	Nervousness
□	□	Depression
□	□	Anxiety
□	□	Past / present psychiatric treatment

Family History (Grandparents, Parents, Sisters, Brothers, Children):

YES	NO	
□	□	Diabetes
□	□	Heart disease
□	□	Bleeding disorders

Allergies:

YES	NO	
□	□	Penicillin / sulfa drugs
□	□	Novocain / Xylocaine / dental anesthetics
□	□	Aspirin / codeine
□	□	Latex products
□	□	Other _____

Females :

YES	NO	
□	□	Are you pregnant now? _____ # months
□	□	Are you practicing birth control?
□	□	Do you anticipate becoming pregnant?
□	□	Are you breast feeding now?

(Patient, or Parent if Minor)

Patient's Acknowledgement of Receipt of Dental Materials Fact Sheet

I, _____, acknowledge I have received from

Patient name

Dr. Shoffet-Yaghoubian a copy of the Dental Materials Fact sheet dated October 2001.

_____ _____

Patient signature *date*

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I,_____ [full name], have received a copy of the Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

Royal Dental Practice
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