

Patients name: _____ Date: _____
 Age: _____ Date of birth: _____ Single Married Widowed Separated Divorced
 If a minor, give name of father / mother or / guardian: _____ / _____ / _____
 Home phone: _____ Cell Phone: _____ Name of spouse: _____
 Home address: _____ City: _____ Zip code: _____
 Your employer: _____ Occupation: _____
 Business address: _____ Business phone: _____
 Spouse employed by: _____ Occupation: _____
 Business address: _____ Business phone: _____
 Name of nearest relative not living with you: _____ Relation: _____
 Address: _____ phone: _____
 Name of dental insurance co.: _____ Policy #: _____
 Name of second plan, if any: _____ Policy #: _____
 Insured's social security #: _____ Spouse's social security #: _____
 Who will pay this account? _____
 How did you find out about us? _____
 Purpose of this call: _____
 Date of last dental visit? _____

I authorize my name to be used as a "signature on file" on any insurance claim and to release any information relating to that claim, and to authorize payment directly to Nadia Navid, D.D.S. I agree that, regardless of insurance coverage, I am responsible for payment for services rendered.

Signature: _____ Date: _____

HEALTH HISTORY

Are you in good health?.....YES NO
 Date of last physical examination: _____ Name of physician: _____
 Are you under the care of a physician? YES NO
 If so, what condition is being treated? _____
 Have you ever had any serious illness or operation?.....YES NO
 If so, what illness or operation? _____
 Have you been hospitalized during the past five years?.....YES NO
 If so, what was the problem? _____
 Are you taking any drugs or medicine?.....YES NO
 If so, list drugs with dosages _____

Are you sensitive or allergic to: Penicillin Erythromycin Aspirin Ibuprofen Codeine Latex
 Other Allergies (please list) _____
 Have you ever had an unfavorable reaction from a local anesthetic?.....YES NO

Do you have or have you had any of the following, please mark the box:

Yes No	Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> High blood pressure	<input type="checkbox"/> <input type="checkbox"/> Pace Maker	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Cortisone medicine
<input type="checkbox"/> <input type="checkbox"/> Heart murmur	<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Glaucoma	<input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> <input type="checkbox"/> Abnormal heart condition	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Ulcers	<input type="checkbox"/> <input type="checkbox"/> Radiation therapy
<input type="checkbox"/> <input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> <input type="checkbox"/> Head/Neck injuries	<input type="checkbox"/> <input type="checkbox"/> Thyroid disease	<input type="checkbox"/> <input type="checkbox"/> Chemo-therapy
<input type="checkbox"/> <input type="checkbox"/> Angina pectoris	<input type="checkbox"/> <input type="checkbox"/> Tumors or growths	<input type="checkbox"/> <input type="checkbox"/> Kidney disease	<input type="checkbox"/> <input type="checkbox"/> Cancer
<input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/> Epilepsy or seizures	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Failure	<input type="checkbox"/> <input type="checkbox"/> Fainting spells	<input type="checkbox"/> <input type="checkbox"/> Emphysema	<input type="checkbox"/> <input type="checkbox"/> Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/> Sinus trouble	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Renal Dialysis
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> <input type="checkbox"/> Fen Fen (for weight loss)
<input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding from a cut	<input type="checkbox"/> <input type="checkbox"/> Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/> Artificial Joint	<input type="checkbox"/> <input type="checkbox"/> Bisphosphonate (i.e. fosamax)

Do you have any disease, condition or problem not listed that you think I should know about?..... YES NO
 If so, what _____
 Do you smoke or use chewing tobacco?..... YES NO
 (Women) Are you Pregnant/Nursing?..... YES NO
 (Women) Do you take birth control pills?..... YES NO
 Are you nervous or anxious in the dental office?..... YES NO
 If so, would you like to be treated with nitrous oxide?..... YES NO

CONSENT FOR TREATMENT: The above health history is correct to the best of my knowledge. I authorize and give consent for dental services agreed to by Doctor and Patient and/or Guardian, including the use of local anesthesia and other medication as indicated.

Signature of Patient, Guardian, or Parent: _____ Signature of Doctor _____