NEW PATIENT INFORMATION

Patient Name: ____________________ Date: __________

Age: _____ Date of Birth: __________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If a minor, name of parents/guardian: ____________________ Spouse Name: __________

Home Phone: __________ Cell Phone: __________ Email: __________

Home Address: ____________________ City: __________ Zip: __________

Employer: ____________________ Occupation: __________

Business Address: ____________________ Business Phone: __________

Spouse Employer: ____________________ Occupation: __________

Business Address: ____________________ Business Phone: __________

Emergency Contact: ____________________ Relation: __________

Address: ____________________ Phone: __________

Name of Dental Insurance: ____________________ Policy/Group #: __________

Name of Secondary Plan, If Any: ____________________ Policy/Group #: __________

Insured's Social Security #: ____________________ Spouses Social Security #: __________

Who will pay this account?: ____________________

How did you find out about us?: ____________________

Purpose of this visit?: ____________________

Date of last dental visit?: ____________________

I authorize my name to be used as "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.

Payment: Payment is due at the time services are rendered. I agree that, regardless of insurance coverage, I am responsible for payment for services rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment.

Scheduling of appointments: To maintain the utmost service and care, we do require at least 48-hour notice to reschedule an appointment. With less than 48-hours notice, a cancellation fee or deposit to reserve the appointment time again may be required.

Cell Phone:

☐ I consent to the dental practice using my cell phone number to (choose one or both) ☐ Call or ☐ Text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

My cell phone number is (include the area code) ____________________ _____ ***(initial)***

Patient Acknowledgements:

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ ***(initial)***

I hereby acknowledge that a copy of this practice's Dental Material Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____ ***(initial)***

Patient Signature: ____________________ **Date: __________**

MEDICAL HISTORY

Date of last physical examination: ______________________ Name of physician: ______________________

Are you under the care of a physician for a specific condition? .... YES NO

If so, what condition is being treated? ______________________

Have you been hospitalized during the past three 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 ☐ Sulfa ☐ Tetracycline ☐ Codeine ☐ Latex ☐ Aspirin ☐ Ibuprofen ☐ Other drug allergies (please list) ______________________

Have you ever had an unfavorable reaction from a local anesthetic? .... YES NO

Have you ever been told to take antibiotics prior to your dental appointments? .... YES NO

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

- ☐ Angina Pectoris
- ☐ Artificial Heart Valve
- ☐ Atrial Fibrilation
- ☐ Heart Attack/Failure date: __________
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Any other heart condition: ______________
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells
- ☐ Head/Neck Injury
- ☐ Memory Impairment
- ☐ Psychiatric Care
- ☐ Stroke date: __________
- ☐ Allergies
- ☐ Asthma
- ☐ Emphysema/C.O.P.D.
- ☐ M.R.S.A.
- ☐ Pulmonary Disease
- ☐ Sinus Trouble
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Renal Dialysis
- ☐ Orthopedic Surgery (Check which one)
  - ___ Hip date: __________
  - ___ Knee date: __________
  - ___ Other ______________ date: __________
- ☐ Cancer Type: ______________ date: __________
- ☐ Chemotherapy
- ☐ Difficulty Swallowing
- ☐ GERD
- ☐ Radiation
- ☐ Sjogren's Syndrome
- ☐ Tumors or Growths
- ☐ Bisphosphonate (i.e. Fosamax)
- ☐ Blood Thinners (i.e. Coumadin)
- ☐ Cortisone Medication

Do you have any disease or condition not listed? .... YES NO

If so, what? ______________________

(Women) Are you pregnant or 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 medications as indicated.

Patient, Guardian, or Parent Signature: ______________________

Doctor Signature: ______________________