WELCOME

GENTLE DENTAL, INC.

KAYVON F. NEZHAD D.D.S.

HEALTH HISTORY & REGISTRATION

Patient's Name ______________ Sex: M F Birthdate ______ Age ____ Today's Date ______
Home Address ______________ City ______ State ______ Zip ______
E-mail Address ______________ Home Phone # ______
Please Circle One: Single, Married, Separated, Divorced, Widowed Occupation ______ Cell Phone # ______
Your Employer ______ How Long Employed? ______ Your Soc. Sec. # ______ Work Phone ______
Are you a full time student ☐ Yes ☐ No **If Patient is a minor we need: Mother's Birthdate** ______ **Father's Birthdate** ______
Name of Spouse (Parent if Minor) ______ Person Responsible For Account ______
Spouse's (Parents') Employer ______ Spouse's Soc. Sec. # ______ Work Phone ______
Referred to us by ______
Reason for this visit ______

EMERGENCY INFORMATION
Name, Address & Telephone of a Relative not living with you ______

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ______
Address ______
Date of Birth ______ Soc. Sec. # ______
Insured's ID# ______ Group # ______
Insured's Employer ______
Insurance Company ______
Insurance Co. Address ______
Insurance Co. Phone # ______
Relationship To Patient ______

DENTAL INSURANCE INFORMATION (Secondary Carrier)

Insured's Name ______
Address ______
Date of Birth ______ Soc. Sec. # ______
Insured's ID# ______ Group # ______
Insured's Employer ______
Insurance Company ______
Insurance Co. Address ______
Insurance Co. Phone # ______
Relationship To Patient ______

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

MEDICAL / DENTAL HISTORY

Circle any of the following which you have had or have at present:

Heart Failure	A.I.D.S.	Bruise Easily
Heart Disease or Attack	Hepatitis A (Infectious)	Emphysema
Angina Pectoris	Hepatitis B (serum)	Tuberculosis (TB)
High Blood Pressure	Liver Disease	Asthma
Heart Murmur	Yellow Jaundice	Hay Fever
Rheumatic Fever	Blood Transfusion	Sinus Trouble
Congenial Heart Lesions	Drug Addiction	Allergies or Hives
Scarlet Fever	Hemophilia	Diabetes
Artificial Heart Valve	Fever Blisters	Thyroid Disease
Heart Pacemaker	Epilepsy or Seizures	Radio Therapy
Heart Surgery	Fainting or Dizzy Spells	Arthritis
Artificial Joints (Hip, Knee)	Nervousness	Rheumatism
Anemia	Psychiatric Treatment	Cortisone Medicine
Stroke	Sickle Cell Disease	Pain in Jaw Joints
Kidney Trouble	Glaucoma	Alcoholism
Ulcers	Chemotherapy	Bleeding Problems
Cosmetic Surgery	Venereal Disease	

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Latex	Erythromycin
Barbituates	Local Anesthetic	Valium
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, Please list: ______

	YES	NO
How LONG SINCE you have seen a Dentist? ______		
Last COMPLETE Dental Exam, Date: ______		
Last FULL MOUTH X-RAYS, DATE: ______ (Machine that rotates around your head, or 16 small films)		
Are you having PROBLEMS now?	☐	☐
WHAT?		
Is you present dental health POOR?	☐	☐
Do you wear DENTURES? (Partials or Full)	☐	☐
Are you UNHAPPY with your SMILE?	☐	☐
Do you have CURRENT HEALTH PROBLEMS?	☐	☐
Are you under a PHYSICIANS CARE now?	☐	☐
For What?		
Are you Currently taking any medication?	☐	☐
If yes, what?		
Are you pregnant?	☐	☐
Do you Smoke?	☐	☐
FAMILY PHYSICIAN: ______ Phone ______		

Is there any other Medical or Dental information that you feel I should know about?

______

CONSENT:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance charge will be added to any overdue balance. I also assign all insurance benefits to the Doctor. I have read, understood and received Dr. Nezhad's HIPPA Privacy Policy.

PATIENT Signature (Parent of Child) ______ Date ______ DENTIST Signature ______