Welcome to our Practice

Ehsan Rezvan, DDS, MS

Date _____

PATIENT INFORMATION...

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION (if different from above)...

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: ..... ❑ Full Time ❑ Part Time ❑ Retired ❑ Not ..... Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

SECONDARY DENTAL INSURANCE COMPANY

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel.(_____) _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑ M ❑ F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel.(_____) _____

Please continue to next page.

EHSAN REZVAN DDS, MS
Periodontics

DENTAL QUESTIONNAIRE

YOUR DENTIST'S NAME _____ FOR HOW LONG: _____
FIRST NAME LAST NAME

HOW FREQUENTLY HAVE YOU HAD YOUR TEETH CLEANED DURING THE PAST 5 YEARS:

❑LESS THAN ONCE A YEAR ❑ONCE A YEAR ❑TWICE A YEAR ❑THREE TIMES A YEAR ❑FOUR TIMES A YEAR

MO/YEAR OF YOUR LAST DENTAL EXAM _____ MO/YEAR OF YOUR LAST DENTAL X-RAYS _____

ARE YOU PRESENTLY SATISFIED WITH THE CONDITION OF YOUR MOUTH AND TEETH (CIRCLE ONE):

❑VERY SATISFIED ❑SATISFIED ❑IT'S O.K. ❑SOMEWHAT DISSATISFIED ❑VERY DISSATISFIED

YES	NO	
❑	❑	DO YOU PRESENTLY HAVE ANY PAIN, DISCOMFORT OR IMPAIRED FUNCTION RELATED TO YOUR MOUTH?
		IF YES, PLEASE DESCRIBE: _____
❑	❑	ARE YOU CURRENTLY AWARE OF ANY INFECTION IN YOUR MOUTH?
		IF YES, PLEASE DESCRIBE: _____
❑	❑	ARE YOU CURRENTLY TAKING ANY ANTIBIOITICS FOR INFECTION? IF SO, WHAT: _____
❑	❑	DO YOUR GUMS EVER BLEED? IF SO, WHEN: _____
❑	❑	DO YOU HAVE A PROBLEM WITH BAD BREATH OR HAVE ANY FRIENDS OR FAMILY MADE YOU AWARE OF THIS?
❑	❑	ARE YOU INTERESTED IN REPLACING LOST TEETH?
❑	❑	DO YOU EVER HAVE ACHES OR PAINS IN YOUR JAW JOINTS, EARS, FACE, NECK OR HEAD?
❑	❑	ARE ANY OF YOUR TEETH TENDER WHEN YOU CHEW HARD FOODS?
❑	❑	ARE ANY OF YOUR TEETH SENSITIVE TO: COLD, HOT, SWEETS, CERTAIN FOODS OR DRINKS?
❑	❑	ARE YOU CONCERNED ABOUT GUM RECESSION AROUND ANY OF YOUR TEETH?
❑	❑	ARE YOU CONCERNED ABOUT THE APPEARANCE OF YOUR TEETH OR MOUTH?
❑	❑	HAVE YOU EVER HAD ORTHODONTIC TREATMENT? ❑WITH BRACES ❑WITH REMOVABLE APPLIANCES
		WHEN DID YOU GO THROUGH ORTHODONTIC CARE? _____
❑	❑	HAVE YOU EVER RECEIVED PERIODONTAL TREATMENT? ❑SCALING/ROOT PLANING ❑GUM SURGERY
		WHEN DID YOU GO THROUGH PERIODONTAL CARE? _____

CHECK ANY OF THE FOLLOWING THAT DESCRIBE YOU OR WHICH APPLY TO YOUR PREVIOUS DENTAL TREATMENT:

- ❑ I TOLERATE MOST DENTAL CARE REASONABLY WELL AND USUALLY REQUIRE MINIMAL USE OF ANESTHESIA
- ❑ I APPRECIATE THE USE OF LOCAL ANESTHETIC – IT ALLOWS ME TO TOLERATE MOST DENTAL CARE REASONABLY WELL
- ❑ I TOLERATE SHOTS IN MY MOUTH WHEN THEY ARE GIVEN WELL
- ❑ I LIKE THE BENEFITS OF NITROUS OXIDE (LAUGHING GAS)
- ❑ I PREFER TO BE SEDATED FOR ANY SURGICAL TREATMENT
- ❑ I PREFER TO BE SEDATED FOR ANY LENGTHY SURGICAL CARE
- ❑ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR FOR MORE THAN AN HOUR
- ❑ I HAVE A HARD TIME SITTING IN THE DENTAL CHAIR VERY LONG DUE TO A NECK, BACK, SPINE PROBLEM
- ❑ I HAVE DIFFICULTY WHEN TILTED BACK IN THE DENTAL CHAIR (DIZZINESS, BREATHING DIFFICULTY, _____

WHAT ARE YOUR GOALS OR PRIORITIES FOR THE HEALTH, FUNCTION AND APPEARANCE OF YOUR TEETH & MOUTH?
(RATE EACH ITEM FROM 1TO 5 WITH 5 YOUR HIGHEST PRIORITY – YOU CAN USE THE SAME NUMBER MORE THAN ONCE)

____BE ABLE TO CHEW FOOD AND EAT WHAT I ENJOY	____AVOID REMOVABLE BRIDGEWORK
____PRESERVE MY TEETH & AVOID DENTURES	____MAKE MY TEETH LONGER OR SHORTER
____BE FREE OF INFECTION	____MAKE MY TEETH LOOK GOOD
____BE FREE OF MOUTH PAIN & TENDERNESS	____HAVE A HEALTHY AND HASSLE-FREE MOUTH

_____ _____ _____
Signature of patient or legal guardian Date Reviewed by

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____ • Are you under the care of a physician? ❑ Yes ❑ No

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Are you immunosuppressed *(possibly from transplant surg.)*	❑	❑	Bleeding tendency	❑	❑	Kidney trouble
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Problems w/ immune system *(possibly from med. / surg.)*	❑	❑	Are you on dialysis
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Jaundice / Liver disease	❑	❑	Arthritis / Joint disease
❑	❑	High blood pressure	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Prosthetic joint / Implant
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Infectious mononucleosis	❑	❑	Osteoporosis / Osteopenia
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Osteonecrosis
❑	❑	Heart attack(s)	❑	❑	Do you smoke *if so, # packs a day*_____	❑	❑	Fainting spells	❑	❑	Stomach ulcers
❑	❑	Irregular heart beat				❑	❑	Convulsions / Epilepsy	❑	❑	Contagious diseases
❑	❑	Cardiac pacemaker	❑	❑	Do you use chewing tobacco	❑	❑	Stroke	❑	❑	Delay in healing
❑	❑	Heart surgery	❑	❑	Blood transfusion	❑	❑	Thyroid trouble	❑	❑	Anemia
❑	❑	Pneumonia / Bronchitis / Chronic cough	❑	❑	Blood disorder	❑	❑	Diabetes	❑	❑	Tumor or growth
❑	❑	Chronic fatigue / Night sweat	❑	❑	Bruise easily	❑	❑	A history of alcohol abuse	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of drug abuse	❑	❑	Sexually transmitted diseases	❑	❑	Are you on a diet
❑	❑	Mental health problems	❑	❑	Eye disease / Glaucoma	❑	❑	Swollen ankles	❑	❑	Contact lenses
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Low blood sugar			
❑	❑	Asthma									

MEDICATION & ALLERGIES...

Are you now taking, or have you ever taken:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood thinners (Coumadin, Aspirin, Advil)									
❑	❑	Any bone density medication or Bisphosphonates (Aredia, Zometa, Fosamax, Actonel)									

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	I have no known allergies.

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X _____ **Signature of patient:** *(Parent or Guardian if Minor)*

X _____ **Date**

I hereby acknowledge that a copy of this office'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.

X _____ **Signature of patient** *(Parent or Guardian if minor)*

X _____ **Date**