Redmond Family Smiles
Navid Farzadfar DDS

PATIENT INFORMATION

(PLEASE NOTE THIS IS FOR SCEDULING INFORMATION PURPOSES ONLY, AFTER SCHEDULING YOU WILL RECEIVE A LINK TO COMPLETE ADDITIONAL FORMS THROUGH OUR SECURE ONLINE SYSTEM)

First Name: _____ Last Name: _____

Mobile: _____Home: _____

Email: _____

Birthdate: _____Driver's License#: _____ SS# _____

Home Address: _____

City _____ State _____ Zip Code: _____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated Gender ❑ M ❑ F

Insurance Name: _____ Phone: _____

Insurance Address: _____

Subscriber Name: _____ Birthdate: _____

Relation to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Dependent ❑ Other

Employer: _____ Employer Phone: _____

Member ID# _____ Group# _____

Patient's Name: _____ Patient's Birthdate: _____

How did you hear about us? ❑ Friend ❑ Spouse ❑ Parent ❑ Internet ❑ Yelp ❑Google ❑Insurance Plan ❑ Employer ❑ Walking ❑ _____

CONSENT

❑ I have answered all health questions to the best of my knowledge

After explanation by the doctor, I hereby authorize the performance of dental services upon the above-named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

ASSIGNMENT OF INSURANCE

I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

I Understand there will be a charge for any missed appointments or appointments not cancelled 48 hours before the appointment time.

_____

Date Patient's Signature

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PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.) _____
Previous Dentist _____Last Visit _____Date of last cleaning_____
Reasons for changing dentists: _____
What problems have you had with past dental treatment? _____
Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why: _____
How often do you brush? _____Do you floss? ❑ Yes ❑ No How if yes often? _____

Please circle Y for yes or N for no for the following:

Y N My gums bleed while brushing or flossing.
Y N I prefer tooth-colored fillings.
Y N I have had orthodontics
Y N I clench or grind my teeth during the day or while sleeping.
Y N I have problems eating.
Y N I have had a facial or jaw injury.
Y N I avoid brushing part of my mouth due to pain
Y N My gums feel tender or swollen
Y N I like my smile.
Y N I want my teeth whiter
Y N I want straight teeth
Y N I want Implants

PATIENTS MEDICAL HISTORY

I consider my health to be (please check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? please circle or mark **Y** for yes or **N** for no for <u>EACH</u> question.

1. Y N Heart Disease
2. Y N Stroke
3. Y N Rheumatic Fever
4. Y N Anemia
5. Y N Tuberculosis or Lung Disease
6. Y N Hay Fever
7. Y N Epilepsy/Seizures
8. Y N Liver Disease
9. Y N Hepatitis; Type ___
10. Y N Excessive Urination and/or Thirst
11. Y N Infectious Mononucleosis (Mono)
12. Y N Sexually Transmitted/Venereal Disease
13. Y N Tumor or Malignancy
14. Y N Radiation Treatment
15. Y N History of Addiction
16. Y N Immune Suppressed Disorder
17. Y N History of Emotional or nervous Disorders
18. Y N Heart Murmur/Mitral Valve Prolapse
19. Y N Congenital Heart Lesions
20. Y N Abnormal Blood Pressure
21. Y N Prolonged Bleeding Disorder
22. Y N Asthma
23. Y N Sinus Trouble
24. Y N Ulcers

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant? If yes, How many weeks? _____
44. Y N Are you nursing?

<u>Please list all medications & vitamins or supplements you are currently taking (Use additional sheet if needed):</u>

25. Y N Jaundice
26. Y N Diabetes
27. Y N Herpes
28. Y N Arthritis
29. Y N Kidney Disease
30. Y N Cancer/Chemotherapy
31. Y N AIDS
32. Y N Glaucoma
33. Y N Hearing Loss
34. Y N Fainting Spells
35. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
    Explain: _____
36. Y N I smoke, chew tobacco or vape.
    If yes, how much per day? _____ Years? ____
37. Y N Have you consumed alcohol within the last 24 hours.
38. Y N I usually take an antibiotic prior to dental treatment.
39. Y N Have you ever taken Fen-Phen or Redux?
40. Y N I have had major surgery:
    Year_____ Type of operation: _____
    Year _____ Type of operation: _____
41. Y N Do you have any other medical problem or medical history NOT listed on this form?
    _____

Are you allergic to any of the following?

45. Y N Aspirin
46. Y N Ibuprofen
47. Y N Sulfa Drugs/Sulfites/Sulfides
48. Y N Local Anesthetics
49. Y N Penicillin (Amoxicillin)
50. Y N Codeine
51. Y N Latex, Metals, Plastics
52. Please list any other Allergies:
    _____

Emergency Contact

Name _____Relationship:_____ Phone: _____

_____

Date Patient's Signature