SILICON VALLEY SMILE SOLUTIONS
AMIR HAGSHENAS, DDS, FAGD

Please complete the following confidential information:

PATIENT REGISTRATION

Patient Information

Patient Name: _____ _____ ____ Preferred Name: _____
Last First M.I.

☐ Male ☐ Female ☐ Age_____ ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____Social Security #:_____Drivers License #: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email: _____

Phone (Home):_____Work:_____Ext_____Best time to call: _____

Fax: _____ Pager: _____ Cell: _____

Preferred appointment times: ☐ Mornings ☐ Afternoons ☐ Any Time Preferred Days: ☐M ☐T ☐W ☐T ☐F

Responsible Party Information

Responsible Party Name: _____ _____ _____ Relationship to Patient: _____
Last First M.I.

☐ Male ☐ Female ☐ Age_____ ☐ Married ☐ Single ☐ Child ☐ Other_____

Birth Date:_____Social Security #:_____Drivers License #: _____

Address: _____
Street Apartment #

_____ _____ _____
City State Zip Code

Email: _____

Phone (Home):_____Work:_____Ext_____Best time to call: _____

Fax:_____ Mobile:_____Pager: _____

Personal and Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend or relative ☐ Specialist
☐ Web (Google, Yahoo, Website search)_____ ☐ Other _____

Name of the person referring you to our practice: _____

Person to contact, in case of emergency:
Name:_____Phone: _____

Address:_____
street city state zip

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Employment Information

The following information is for: ☐ The Patient ☐ The Responsible Party (Relationship to Patient_____)

Patient's Occupation:_____ Employer Name: _____

Address: _____
Street City State Zip Code

Employer's Phone Number: _____

Insurance Information

Primary Insurance:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Name of the Insured: _____ _____ _____ Is the insured a patient? ☐ Yes ☐ No
Last First M.I.

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insured's Employer Name: _____

Insurance Name and Address: _____

Insurance Phone Number: _____

Secondary Insurance:

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Name of the Insured: _____ _____ _____ Is the insured a patient? ☐ Yes ☐ No
Last First M.I.

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insured's Employer Name: _____

Insurance Name and Address: _____

Insurance Phone Number: _____

Consent for Services

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medications as necessary. I fully understand that the use of such medications embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless prior arrangements are made. A service charge of 1½% per month (18% APR) on the unpaid balance will be charged on all accounts exceeding 60 days without fully satisfied prior financial arrangements.

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 also understand that a check of my credit history may be made.

I have read the above conditions of treatment and agree to their content.

_____ Date:_____ Relationship to Patient: _____
(Signature of patient, parent or responsible party)

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MEDICAL HISTORY

Patient Information

Patient Name:_____ Date: _____
Last First MI (Preferred Name)

Have your ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Mitral Valve Prolapse
- ☐ Nursing
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Herpes
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex sensitivity
- ☐ Radiation
- ☐ Chemotherapy
- ☐ OTHER:_____

☐ Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

☐ Have you been admitted to a hospital or for emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

☐ Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

☐ Name of Physician:_____ Phone:_____

☐ Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

☐ Current Medications (Both Prescription and Over the Counter):

_____ _____

☐ Adverse reactions to medications in the past:

_____ _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor before the next appointment.

_____ Date:_____
Signature of patient, parent or guardian

Office Use Only

History Review:

Dentist's Signature:_____ Date: _____

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Welcome! **Please share the following confidential information:**

DENTAL HISTORY

Patient's Name:_____ **Date:** _____

A. Reason for Your Visit:
Do you have any other dental problems now? If yes, please describe:

_____

B. Your Dental History:
Date of your last dental treatment:_____ Last cleaning:_____ Last full mouth x-rays: _____
Previous Dentist's Name: _____
Address:_____ Stat_____ Zip_____
Telephone:_____
How often have you had dental examination in the past? _____

C. Your Gums:

Do your gums bleed?	No	Yes	How often? _____
Do you have any bad odors or tastes?	No	Yes	Where? _____
Have you had gum treatment?	No	Yes	What type? _____
Have your parents had gum disease?	No	Yes	Which parent? _____
Have your parents experienced tooth loss?	No	Yes	Which parent? _____
Do you smoke or chew tobacco?	No	Yes	Which one? _____

D. Your Teeth:

Are you sensitive to hot or cold?	No	Yes	Where? _____
Are you sensitive to sweets?	No	Yes	Where? _____
Are your teeth sensitive to biting/chewing?	No	Yes	Where? _____
Does food get caught between your teeth?	No	Yes	Where? _____
Have you had oral surgery or extractions?	No	Yes	What type? _____

E. Your Bite:

Do you grind your teeth while you sleep?	No	Yes	Comments? _____
Have you had a clicking or popping jaw?	No	Yes	When? _____
Have you had pain in ear, joint, or face?	No	Yes	When? _____
Do you have aches in neck, or shoulders?	No	Yes	Where? _____
Do you have sore or tired jaws?	No	Yes	How often? _____
Do you get frequent headaches?	No	Yes	How often? _____
Have you had braces before?	No	Yes	When? _____
Have you had head/ neck trauma before?	No	Yes	When? _____
Have you had night guards or bite guards?	No	Yes	Which kind? _____

F: Your Appearance:
Are you satisfied with the appearance of your teeth? If not, please describe?

_____

_____

Additional Comments: Is there anything else about your dental treatment that you would like us to know?

_____

_____

G. Other:
Have you had an upsetting dental experience in the past? If yes, please describe:

_____