

**GET ACQUAINTED QUESTIONNAIRE**

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Fax ( ) \_\_\_\_\_ E-Mail \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
How long? \_\_\_\_\_ Own? \_\_\_\_\_ Rent? \_\_\_\_\_ Previous Address \_\_\_\_\_  
Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
What is the purpose of this visit? \_\_\_\_\_  
If a student, school attended \_\_\_\_\_ Full Time? \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_  
Driver's License No. \_\_\_\_\_ Social Security No. \_\_\_\_\_  
In case of emergency, please provide us with the name and address of closest relative or friend  
not living with you.

His/Her Telephones: Home ( ) \_\_\_\_\_ Business ( ) \_\_\_\_\_  
Who is financially responsible for this bill? \_\_\_\_\_ Social Security \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Name of insurance Carrier for you: \_\_\_\_\_ Spouse \_\_\_\_\_  
Name of Group Dental Plan \_\_\_\_\_ Group Number \_\_\_\_\_

If you have dental insurance, we will help you to determine the approximate coverage you have available. We ask that you assign your insurance benefits to us, unless you pay full in advance. Professional care is provided to you, our patient, and not to an insurance company. Thus the insurance company is responsible to you the patient and you, the patient are responsible to compensate the doctor. We will help in every way we can in filling your claim and/or handling insurance questions on your behalf. Accounts outstanding more than 30 days from treatment date will bear interest at 1.5% per month or 18% per year. Patient agrees to pay reasonable attorney or collection agency fees and court costs in the event that collection effort or legal action is required to enforce payment.

In order to satisfy an outstanding balance, the following credit card may be used:  
 Visa       Master Card       American Express       Discover  
Account No. \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF PATIENT RECORDS**

I authorize Dr. Alidadi and Team to release x-rays and treatment information to other treating dentist and insurance companies. I release Dr. Alidadi and Team from any liability related to disclosure of confidential or privileged information.

\_\_\_\_\_  
Patient's Signature or Parent's Signature \_\_\_\_\_ Today's Date \_\_\_\_\_

**THANK YOU FOR YOUR COOPERATION**

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For Office Use Only

Special precautions: \_\_\_\_\_ HB: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for records only and will be considered confidential.

## DENTAL

1. Reason for today's visit: Dental Emergency Initial Consultation Check Up Cleaning Other \_\_\_\_\_  
Chief Complaint \_\_\_\_\_

2. Date of last Dental Visit \_\_\_\_\_ What treatment was performed \_\_\_\_\_ Date of last X-ray \_\_\_\_\_

3. Date of last Dental Cleaning \_\_\_\_\_ Name of previous Dentist \_\_\_\_\_ Telephone # \_\_\_\_\_

4. Do you use electronic manual toothbrush Fluoride Rinse yes no Dental Floss yes no Other \_\_\_\_\_

5. Have you received Oral Hygiene instructions regarding the care of your teeth and gums yes no

6. Check (✓) if you have had problems with any of the following:

Bad Breath Broken Teeth Grinding, clenching teeth Bleeding gums Clicking or popping jaw

Food collection between teeth Difficulty opening or closing jaw Loose teeth

Sores or Growth in your mouth Shifting of teeth Loose or poor fitted dental prosthesis

Sensitivity to Hot Cold Sweets When biting down Dark, discolored teeth

7. Do you Dentures or Partial Yes No 8. Have you ever had orthodontic treatment Yes No

9. Have you ever had dental implants Yes No 10. Do you require Antibiotics before dental treatment Yes No

11. Have you ever been treated for periodontal disease (Gum disease, pyorrhea) Yes No If so, When \_\_\_\_\_

12. Have you ever had any problems or complications with previous dental treatments Yes No

13. Have you ever had any unpleasant dental experience or is there anything about dentist that you strongly dislike Yes No

14. Do you like your smile Yes No 15. Would you like your teeth whiter Yes No

16. Are there any cosmetic changes you would like to have done to your teeth Yes No

I certify that I have read and understand the above information to the best of my knowledge and have correctly answered. I understand that incorrect information can be dangerous to my health. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

I hereby give my consent for the performance of a complete oral-facial examination including but not limited to x-rays and photographs.

Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY**

**I. CIRCLE THE APPROPRIATE ANSWER:** (Leave blank if you do not understand the question)

- 1. Yes No Is your general health good?      2. Yes No Has there been a change in your health within the last year?
- 3. Yes No Have you been hospitalized or had a serious illness in the last three years?  
If YES, why? \_\_\_\_\_
- 4. Yes No Are you now under the care of a physician?      Date of last medical exam? \_\_\_\_\_
- 5. Physician's name \_\_\_\_\_      6. Telephone number \_\_\_\_\_

**II. HAVE YOU EXPERIENCED:**

- 7. Yes No Chest pain (angina)
- 8. Yes No Swollen ankles
- 10. Yes No Recent weight loss, fever night sweats
- 11. Yes No Persistent cough, coughing up blood
- 12. Yes No Bleeding Problems, bruising easily
- 13. Yes No Sinus problems
- 14. Yes No Difficulty swallowing
- 15. Yes No Diarrhea, constipation, blood in stool
- 16. Yes No Frequent vomiting, nausea
- 17. Yes No Difficultly urinating, blood in urine
- 18. Yes No Dizziness
- 19. Yes No Ringing in ears
- 20. Yes No Headaches
- 21. Yes No Fainting Spells
- 22. Yes No Blurred vision
- 23. Yes No Seizures
- 24. Yes No Excessive thirst
- 25. Yes No Frequent urination
- 26. Yes No Dry mouth
- 27. Yes No Joint pain, stiffness

**III. DO YOU OR HAVE YOU HAD:**

- 29. Yes No Heart Disease
- 30. Yes No Heart attack, heart defects
- 31. Yes No Heart Murmurs
- 32. Yes No Rheumatic fever
- 33. Yes No Stroke, hardening of arteries
- 34. Yes No High Blood Pressure
- 35. Yes No Asthma, TB, emphysema, other lung diseases
- 36. Yes No Hepatitis, other liver disease
- 37. Yes No Stomach problem, ulcers
- 38. Yes No Allergies to: drugs, foods, medications, latex
- 39. Yes No Family history of diabetes, heart problems
- 40. Yes No AIDS, HIV +
- 41. Yes No Tumors, cancer
- 42. Yes No Arthritis, rheumatism
- 43. Yes No Eye Diseases
- 44. Yes No Skin diseases
- 45. Yes No Anemia
- 46. Yes No VD, (syphilis, gonorrhea)
- 47. Yes No Herpes
- 48. Yes No Kidney, bladder disease
- 49. Yes No Thyroid, adrenal disease
- 50. Yes No Diabetes

**IV. DO YOU OR HAVE YOU HAD:**

- 51. Yes No Psychiatric care
- 52. Yes No Radiation treatment
- 53. Yes No Chemotherapy
- 54. Yes No Prosthetic heart valve
- 55. Yes No Artificial joint
- 56. Yes No Hospitalization
- 57. Yes No Blood transfusions
- 58. Yes No Surgeries
- 59. Yes No Pacemaker
- 60. Yes No Contact lenses

**V. ARE YOU TAKING:**

- 61. Yes No Antibiotics/Sulfa drugs
- Yes No Blood thinners
- Yes No Blood Pressure
- Yes No Thyroid medication
- Yea No Cortisone/steroids
- Yes No Antihistamines/Allergy drugs
- 62. Yes No Tobacco in any form; alcohol
- 63. Yes No Are you or could you be pregnant or nursing
- 64. Yes No Are you taking hormone medication
- 65. Yes No Do you or have you had any other diseases or medical problems NOT listed on this form?
- Yes No Tranquilizers
- Yes No Insulin, other diabetes drugs
- Yes No Recreational drugs
- Yes No Digitalis, other heart medications
- Yes No Nitroglycerine
- Yes No Aspirin
- Yes No Other medications \_\_\_\_\_

**To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INFORMED CONSENT**

I authorize Dr. Alidadi and staff to perform dental services for \_\_\_\_\_, as verbally agreed upon, and/or as indicated on the treatment plan in the chart, as long as \_\_\_\_\_, am/is patient in the office. I understand the recommended treatment, associated fees, and required time.

These dental services may include surgery deemed necessary or advisable as a corollary to the planned treatment. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition or different from those now contemplated, I further request and authorize the doctor to do whatever he/she deems advisable.

I have been informed and understand that occasionally there are complications of the treatment \* drugs and anesthesia including plain \* infection \* swelling \* bleeding \* discoloration \* numbness and tingling of the lip, tongue, chin, gum, cheeks and teeth \* pain and numbness \* and thrombophlebitis (inflammation to a vein) from intravenous and intramuscular injection \* injury to and stiffening of neck and facial muscles \* change in occlusion or temporomandibular joint difficulty \* injury to adjacent teeth or restorations in other teeth \* injury to other tissues \* referred pain to ear, neck and head \* nausea \* vomiting \* allergic reactions \* bone fractures \* bruises \* delayed healing \* sinus complications and nasal antral fistulas and openings \* sore lips, cheeks \* speech alteration.

Tooth sensitivity to hot or cold may persist for several weeks, months, or, in rare instances, permanently; gum recession (shrinkage); temporary, or, in rare instances, permanent interference with phonetics (speech sounds); clicking, pain and disfunction in temporomandibular joints (jaw joints); tooth mobility (looseness); varying degree of spaces between teeth resulting in food becoming caught between the teeth after eating; and unesthetic exposure of crown (cap) margins may result from dental and/or periodontal therapy.

I further understand that if no treatment is rendered, my present dental and/or periodontal condition will probably worsen in time, which may result in premature tooth loss.

Every effort upon the part of the doctor and staff will be made to attain a successful result, however no guarantee or warranty can be given to me that the proposed treatment will be successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition is unlikely, yet may occur. I understand that long-term success also requires my continue cooperation with daily prevention (home plaque control and nutrition) and periodic maintenance visits for an indefinite period of time.

I consent to photographs (kodachromes) of my oral facial structures and their publication for educational and scientific purposes.

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I certify that I have read fully and understand the above consent to the operation, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Patient or Legal Guardian

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Signature of Patient or Legal Guardian