

Roya Arbab DDS



Date: _____

Patient Information

Name _____ Preferred Name _____

Sex _____ Birth Date _____ SSN _____

Married _____ Widowed _____ Single _____ Other _____

Address _____

Telephone: Home _____ Work _____ Cell _____

E-mail _____

Employer _____ Occupation _____

Employer Address _____

Emergency Contact _____ Phone _____

Whom may we thank for referring you? _____

Responsible Party

Name Responsible for Account _____ Relation to patient _____

Address _____

DOB _____ Driver's License _____ Phone _____

Employer _____ Work phone _____

Insurance Information

Name of Insured _____ Relation to Patient _____

Member ID/SSN# _____ DOB _____

Member's Employer _____

Insurance company _____ Group# _____

Insurance address _____

Insurance phone _____

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed? _____ YES NO

SMILE CHARACTERISTICS

7. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
8. Have you ever whitened (bleached) your teeth? _____ YES NO
9. Are you self conscious about your teeth? _____ YES NO
10. Have you been disappointed with the appearance of previous dental work? _____ YES NO

BITE AND JAW JOINT

11. Do you / would you have any problems chewing gum? _____ YES NO
12. Do you / would you have any problems chewing bagels or other hard foods? _____ YES NO
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
14. Are your teeth crowding or developing spaces? _____ YES NO
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____ YES NO
16. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ YES NO
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
18. Do you have tension headaches or sore teeth? _____ YES NO
19. Do you wear or have you ever worn a bite appliance? _____ YES NO

TOOTH STRUCTURE

20. Have you had any cavities within the past 3 years? _____ YES NO
21. Do you have a dry mouth? _____ YES NO
22. Are any teeth sensitive to hot, cold, biting or sweets? _____ YES NO
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____ YES NO
24. Do you avoid brushing any part of your mouth? _____ YES NO
25. Do you feel or notice any holes (i.e. pitting) in your teeth? _____ YES NO

GUM AND BONE

26. Have you ever been diagnosed or treated for periodontal (gum) disease? _____ YES NO
27. Have you ever experienced gum recession? _____ YES NO
28. Is there anyone with a history of periodontal disease in your family? _____ YES NO
29. Do your gums bleed when brushing, flossing or eating? _____ YES NO
30. Are your teeth becoming loose? _____ YES NO
31. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
32. Have you experienced a burning sensation in your mouth? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD:

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to			27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen			28. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			29. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			30. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			31. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> codeine			32. neurologic problems _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			33. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			34. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (gold, stainless steel)			35. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			36. venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> any other medications _____			37. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems _____	<input type="checkbox"/>	<input type="checkbox"/>	38. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	39. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	40. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	41. chemotherapy _____	<input type="checkbox"/>	<input type="checkbox"/>
7. high blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	42. emotional problems _____	<input type="checkbox"/>	<input type="checkbox"/>
8. low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	43. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. a stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	44. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. artificial prosthesis (i.e. heart valve or joints) _____	<input type="checkbox"/>	<input type="checkbox"/>	45. alcohol / drug dependency _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>			
12. prolonged bleeding due to a slight cut _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
13. emphysema _____	<input type="checkbox"/>	<input type="checkbox"/>	46. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	47. aware of a change in your general health _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	48. taking medication for weight management (i.e. fen-phen) _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	50. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	51. subject to frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	52. a smoker or smoked previously _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid or parathyroid disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. considered a touchy person _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	54. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol _____	<input type="checkbox"/>	<input type="checkbox"/>	55. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	57. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
25. digestive disorders (i.e. gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____