Ali Haeri D.M.D M.H.S
Dental Implants | Periodontics

Welcome

and thank you for choosing Dr. Haeri D.M.D, M.H.S, as your service provider. Please fill out form below.

Patient Information

Date _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

S.S# or Ins. ID # _____

Email _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient Employer/School _____

Patient Employer/School address _____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Who may be thank for referring you? _____

Dental Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by addition insurance? ☐ Yes ☐No

Subscriber's Name _____

Birthdate _____ Group # _____

Relationship to Patient _____

Insurance Co. _____

SS# or Ins. ID # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my depentdent(s), have insurance coverage with _____ and assigned directly to
Name of Insurance Company(ies)

Dr. Ali Haeri D.M.D, M.H.S, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____ _____
Date Relationship to Patient

Phone Numbers

Home (_____) _____ Work (_____) _____ Ext. _____ Cell Phone (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

In case of emergency, contact

Name _____ Relationship _____

Dental History

Reasons for today's visit _____

_____

General Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental x-ray _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Burning sensation on tongue	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No
		Clicking or popping jaw	☐ Yes ☐ No
		Dry mouth	☐ Yes ☐ No
		Fingernail biting	☐ Yes ☐ No
		Food collection between the teeth	☐ Yes ☐ No
		Gringding teeth	☐ Yes ☐ No
		Gums swollen or tender	☐ Yes ☐ No
		Jaw/muscle pain or tiredness	☐ Yes ☐ No
		Lip or cheek biting	☐ Yes ☐ No
		Loose teeth or broken fillings	☐ Yes ☐ No
		Mouth breathing	☐ Yes ☐ No
		Mouth pain with brusing	☐ Yes ☐ No
		Orthodontic treatment	☐ Yes ☐ No
		Periodontal treatment	☐ Yes ☐ No
		Sensitivity to cold	☐ Yes ☐ No
		Sensitivity to heat	☐ Yes ☐ No
		Sensitivity to sweets	☐ Yes ☐ No
		Sensitivity when biting	☐ Yes ☐ No
		Sores or growths in your mouth	☐ Yes ☐ No
		How often do you floss? _____	
		How often do you brush? _____	
		Dental tools used _____	

- OVER -

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

Age, Weight, and Sex: ☐

Under physician's care? (Cardiologist, Medical Doctor, Etc.) Please provide name and number. ☐ Yes ☐ No If yes _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes _____

Were you asked to premedicate prior to dental appointments/cleanings? ☐ Yes ☐ No If yes _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No If yes _____

Have you ever taken Fosamax, Boniva,Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No If yes _____

Are you on a special diet? ☐ Yes ☐ No If yes _____

Do you use tobacco? Please indicate how often. ☐ Yes ☐ No If yes _____

Office Use: Physical Status? ☐

Women: Are you...

☐ Pregnant ☐Nursing ☐Taking oral contraceptives ☐Trying to get pregnant

Are you allergic to any of the following?

☐ Asprin ☐ Penicillan ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Local Anesthetics ☐ Vicodin

Is there an unlisted allergy? If so, please specify: _____

Do you use controlled substances? ☐ Yes ☐ No If yes _____

Do you have, or have had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiaation Treatments	☐ Yes ☐ No
Alzhemier's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Breathing Problems	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stoke	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Mital Valve Prolapse	☐ Yes ☐ No	Tonsilities	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Yellow Jaundice	☐ Yes ☐ No	Chronic Obstructive Pulmonary COPD	☐ Yes ☐ No	Gout	☐ Yes ☐ No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes _____

Comments:

To the best of my knowledge, the questions on this been form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ Signature of Patient, Parent or Guardian

_____ Date