Ramin Azghandi, DDS, PA
Periodontics & Implants

Patient's Name:_____
First Middle Last Name you like to be called
Birthdate:_____Age:_____ ☐Male ☐Female ☐ Married ☐ Single

Address_____
City, State, Zip_____
SS # _____
Employer _____
Work Phone _____
Spouse's Name _____
Employer_____

Cell Phone_____
Home Phone_____
Email_____
Occupation_____
Is it ok to call you at work? ☐Y ☐N
Occupation_____
Work Phone_____

Whom may we thank for referring you to our office?_____
Has a friend or family member ever been to our office? ☐Y ☐N Their name:_____

In case of emergency contact:

Name:_____ Relationship:_____
Home Phone: _____ Cell Phone: _____

Responsible Party Information:

Primary Insurance Company_____
Subscriber'sname_____
Subscriber's ID_____

Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Dependant
Subscriber's Birthdate_____

Secondary Insurance Company_____
Subscriber's name_____
Subscriber's ID_____

Patient's Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Dependant
Subscriber's Birthdate _____

Dental History:

Reason for today's visit:_____
Dentist's name:_____ Last visit:_____
Are you currently in pain? ☐Y☐N
Do you require antibiotics before dental visits? ☐Y☐N
Are you anxious about dental visits? ☐Y☐N

Please check if "yes" to indicate if you have ever had any of the following:

☐ Bad Breath
☐ Bleeding Gums
☐ Cigarette, pipe or cigar smoking
☐ Dry Mouth
☐ Food collection between teeth
☐ Grinding teeth
☐ Gums swollen or tender
☐ Jaw pain or tiredness
☐ Loose teeth or fillings
☐ Mouth Breathing
☐ Mouth pain when brushing
☐ Orthodontic Treatment

Other _____

How often do you brush?_____ How often do you floss? _____

Please continue on next page.....

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Medical History:

Physician's name:_____ Date of last visit: _____

Your current health is ☐Good ☐Fair ☐Poor
Are you currently a physician's care? ☐Y☐N
Please explain: _____
Do you smoke or use tobacco in any other form?
☐Y☐N
Have you ever taken Phen-Fen, Redux or Pondimin?
☐Y☐N

For women:
Are you taking birth control pills? ☐Y☐N
Are you pregnant? ☐Y☐N
Due Date: _____
Are you nursing? ☐Y☐N

Please check if "yes or no" to indicate if you have ever had any of the following:

☐Y☐N AIDS/HIV
☐Y☐N Anemia
☐Y☐N Arthritis, Rheumatism
☐Y☐N Artificial Heart Valves
☐Y☐N Artificial Joints
☐Y☐N Back Problems
☐Y☐N Bleeding abnormally with extractions or surgery
☐Y☐N Blood Disease
☐Y☐N Cancer
☐Y☐N Chemical Dependency
☐Y☐N Chemotherapy
☐Y☐N Circulatory Problems
☐Y☐N Congenital Heart Lesions
☐Y☐N Cortisone Treatments
☐Y☐N Cough, persistent or bloody
☐Y☐N Diabetes –Type 1 or 2
☐Y☐N Emphysema
☐Y☐N Epilepsy
☐Y☐N Fainting or dizziness
☐Y☐N Glaucoma
☐Y☐N Headaches
☐Y☐N Heart Murmur
☐Y☐N Heart Problems
☐Y☐N Hepatitis Type _____
☐Y☐N Herpes
☐Y☐N High Blood Pressure
☐Y☐N Jaundice
☐Y☐N Jaw Pain
☐Y☐N Kidney Disease
☐Y☐N Liver Disease
☐Y☐N Mitral Valve Prolapse
☐Y☐N Nervous Problems
☐Y☐N Pacemaker
☐Y☐N Psychiatric Care
☐Y☐N Radiation Treatment
☐Y☐N Respiratory Disease
☐Y☐N Scarlet Fever
☐Y☐N Shortness of Breath
☐Y☐N Sinus Trouble
☐Y☐N Stroke
☐Y☐N Swollen Feet or Ankles
☐Y☐N Thyroid Problems
☐Y☐N Tonsillitis
☐Y☐N Tuberculosis
☐Y☐N Tumor or Growth on Head or Neck
☐Y☐N Ulcer
☐Y☐N Venereal Disease
☐Y☐N Weight Loss, Unexplained
☐ Other_____
_____

Medications:

Please list any medications you are currently taking and the correlating diagnosis:

Allergies:

Please check if "yes" to indicate if you are allergic to any of the following:

☐Aspirin	☐Barbiturates	☐Codeine	☐Dental Anesthetics
☐Erythromycin	☐Jewelry or Metals	☐Latex	☐Penicillin
☐Sedatives	☐Sulfa Drugs	☐Tetracycline	☐Other

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment has been made, please remember this time has been reserved for you.

X _____ Date:_____
Signature of patient or parent if minor.