
**Ali Shirani, D.D.S.**

3725 Lone Tree Way, Suite F
Antioch, California 94509

## PATIENT INFORMATION

Date _____ Name (Last, First, Middle Initial) _____

Social Security # _____ Cell # _____ Home # _____

Address _____ City _____ State _____ Zip Code _____

Sex M ○ F ○ Age _____ Birthdate _____ Single ○ Married ○ Widowed ○ Divorced ○

Employer _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____ E-mail _____

In case of an emergency, whom should we notify? _____ Phone _____

## PRIMARY INSURANCE

Person responsible for account _____ Birthdate _____

Relationship to patient _____ Social Security # _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Person responsible employed by _____ Occupation _____

Business address _____ Phone _____

Insurance company _____

Contract# _____ Group# _____ Subscriber# _____

Other dependents covered on plan _____

## SECONDARY INSURANCE

Is the patient covered by additional insurance? Yes ○ No ○

Subscriber Name _____ Relationship to patient _____

Social Security # _____ Birthdate _____

Address (if different than patient's) _____ Phone _____

City _____ State _____ Zip Code _____

Subscriber employed by _____ Occupation _____

Business address _____ Phone _____

Insurance company _____

Contract# _____ Group# _____ Subscriber# _____

Other dependents covered on plan _____

## AUTHORIZATION

**I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorized the use of my signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of my benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.**

Signature _____ Date _____

***Payment is due in full at time of treatment unless prior arrangements have been approved.***

## MEDICAL HISTORY

Personal Physician's Name _____

Phone _____

**Current Physical Health Is:** **Good** ○ **Fair** ○ **Poor** ○

Are you currently in the care of a personal physician? ○Y ○N

Please explain _____

Do you use tobacco in any form? ○Y ○N

Have you had any metal rods, pins of implants? ○Y ○N

Are you taking any prescription/over the counter drugs? ○Y ○N

Please list _____

Have you ever taken phen-fen, also called redux or pondimin? ○Y ○N

If so, when? _____

**Have you ever had any of the following disease or medical problems?**

| | |
|---|---|
| ○Y○N Abnormal Bleeding | ○Y○N Hepatitis |
| ○Y○N AIDS | ○Y○N Herpes/Fever Blisters |
| ○Y○N Alcohol/Drug Abuse | ○Y○N High Blood Pressure |
| ○Y○N Anemia | ○Y○N HIV |
| ○Y○N Arthritis | ○Y○N Hospitalization |
| ○Y○N Artificial Bones/Joints/Valves | ○Y○N Kidney Problems |
| ○Y○N Asthma | ○Y○N Liver Disease |
| ○Y○N Blood Transfusion | ○Y○N Low Blood Pressure |
| ○Y○N Cancer/Chemotherapy | ○Y○N Mitral Valve Problems |
| ○Y○N Colitis | ○Y○N Pacemaker |
| ○Y○N Congenital Heart Defect | ○Y○N Psychiatric Problems |
| ○Y○N Diabetes | ○Y○N Radiation Treatment |
| ○Y○N Difficulty Breathing | ○Y○N Rheumatic/Scarlet Fever |
| ○Y○N Emphysema | ○Y○N Seizures |
| ○Y○N Epilepsy | ○Y○N Shingles |
| ○Y○N Fainting Spells | ○Y○N Sickle Cell disease |
| ○Y○N Frequent Headaches | ○Y○N Sinus Problems |
| ○Y○N Glaucoma | ○Y○N Stroke |
| ○Y○N Hay Fever | ○Y○N Thyroid Problems |
| ○Y○N Heart Attack/Surgery | ○Y○N Tuberculosis (TB) |
| ○Y○N Heart Murmur | ○Y○N Ulcers |
| ○Y○N Hemophilia | ○Y○N Venereal Disease |
| ○Y○N Fosomax/Bisphosphonates | |

Please list any serious medical condition(s) you may have had:

_____

_____

**Are you allergic to any of the following?**

| | |
|---|---|
| ○Y○N Aspirin | ○Y○N Latex |
| ○Y○N Codeine | ○Y○N Penicillin |
| ○Y○N Dental Anesthetics | ○Y○N Tetracycline |
| ○Y○N Erythromycin | ○Y○N Other |
| ○Y○N Jewlry/Metals | |

Please list any other medications you are allergic to:

_____

**Women**

Are you taking birth control pills? ○Y ○N

Are you pregnant? Week# _____ ○Y ○N

Are you nursing? ○Y ○N

## DENTAL HISTORY

**Why Have You Come To The Dentist Today?**

_____

Previous Dentist _____

Phone _____ Date Of Last Visit _____

Reason For Change _____

**Current Dental Health Is:** ○ **Good** ○ **Fair** ○ **Poor**

Are you currently in pain? ○Y ○N

Do you require antibiotics before dental treatment? ○Y ○N

Have you ever had a problem with any previous dental work? ○Y ○N

Do you floss daily? ○Y ○N

Type of bristles on toothbrush? Hard ○ Med ○ Soft ○

Have you ever had gum treatment? ○Y ○N

Do your gums ever bleed? ○Y ○N

Have you ever had periodontal disease? ○Y ○N

Have you ever had pain/discomfort in your jaw joint? ○Y ○N

TMJ/TMD

Do you have mobility in your teeth? ○Y ○N

Are you sensitive to: ○ Heat ○ Cold ○ Sweet ○ Other

**Are you happy with the way your smile looks?** ○Y ○N

If not, what would you change?

_____

I have received the dental materials sheet.

Initials _____ Date _____

*I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the office staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.*

Signature _____

Date _____

## OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient named herein. Initials _____ Date _____

Doctors Comments: _____

_____

_____

Medical History Update

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____

Has there been any change in your health status since your last visit? ○Y ○N

If yes, explain _____

Patient Initials _____ Date _____

Doctors Initials _____ Date _____