Irvine Smile Design
General, Cosmetic and Implant Dentistry

WELCOME

PATIENT INFORMATION

Date: _____

SS #: _____ Date of birth: _____

Sex: ___ M ___ F Age: _____

Patient Name:

_____

Last Name First Name Middle Initial

Preferred Name:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Occupation: _____

Employer/ School: _____

_____Married ___ Widowed ___ Single ___ Minor

___ Separated ___ Divorced ___Partnered for ____ years

How did you hear about our office?

_____

PHONE NUMBERS (To reach you regarding appointments)

Home: (_____) _____

Work: (_____) _____

Cell Phone: (_____) _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone/ Cell: (_____) _____

Work Phone: (_____) _____

DENTAL INSURANCE

PLEASE PROVIDE INSURANCE CARD TO RECEPTIONIST

Who is responsible for this account?

Name: _____

DOB: _____

ID/SS: _____

Employer: _____

Relationship to Patient: _____

Insurance Co. _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay Drs. Mogari, Brown, & Soleimani all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Irvine Smile Design to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand payment is due in full at the time of treatment. I understand that I will be charged for a broken appointment fee when less than 48 hours notice is given and this amount must be paid before any future care can be given. I acknowledge I have received the HIPAA Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Date of last full mouth X-rays: _____

How often do you floss? _____

How often do you brush? _____

Is there anything you want to change about your smile? _____

Name: _____ **Date of birth:** _____

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

Bad breath	___ Yes ___ No	Gums swollen or tender	___ Yes ___ No
Bleeding gums	___ Yes ___ No	Jaw pain or Headaches	___ Yes ___ No
Cigarette, pipe, or cigar smoking	___ Yes ___ No	Orthodontic treatment	___ Yes ___ No
Clicking or popping jaw	___ Yes ___ No	Pain around ear (ringing)	___ Yes ___ No
Dry Mouth	___ Yes ___ No	Sensitivity with teeth	___ Yes ___ No
Grinding teeth (Clench)	___ Yes ___ No	Snoring while you sleep?	___ Yes ___ No

HEALTH HISTORY

Physician's Name _____ Telephone _____ Date of last visit: _____

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

AIDS/HIV	___ Yes ___ No	Bruise Easily	___ Yes ___ No
Artificial Heart Valves	___ Yes ___ No	Chemical Dependency	___ Yes ___ No
Pacemaker	___ Yes ___ No	Circulatory Problems	___ Yes ___ No
Heart Attack	___ Yes ___ No	Cortisone Treatments	___ Yes ___ No
Any metal pins in the body	___ Yes ___ No	Cough (persistent or bloody)	___ Yes ___ No
Any Implants (Breast)	___ Yes ___ No	Do you wear contact lenses?	___ Yes ___ No
High Blood Pressure	___ Yes ___ No	Epilepsy	___ Yes ___ No
Artificial Joints	___ Yes ___ No	Fainting or dizziness	___ Yes ___ No
Diabetes	___ Yes ___ No	Headaches	___ Yes ___ No
Radiation Treatment	___ Yes ___ No	Herpes	___ Yes ___ No
Cancer	___ Yes ___ No	Jaw Pain	___ Yes ___ No
Chemotherapy	___ Yes ___ No	Liver Disease	___ Yes ___ No
Ulcerative Colitis	___ Yes ___ No	Low Blood Pressure	___ Yes ___ No
Heart Problems	___ Yes ___ No	Psychiatric Care	___ Yes ___ No
Hepatitis Type ____	___ Yes ___ No	Respiratory Disease	___ Yes ___ No
Kidney Disease	___ Yes ___ No	Sinus Trouble	___ Yes ___ No
Anemia	___ Yes ___ No	Stroke	___ Yes ___ No
Arthritis, Rheumatism	___ Yes ___ No	Thyroid Problems	___ Yes ___ No
Asthma	___ Yes ___ No	Tuberculosis	___ Yes ___ No
Back Problems	___ Yes ___ No	Ulcer	___ Yes ___ No
Bleeding abnormally,	___ Yes ___ No	Venereal Disease	___ Yes ___ No
(with extractions or surgery)		Weight Loss, unexplained	___ Yes ___ No
Blood Disease (Transfusion)	___ Yes ___ No	Cold Sores	___ Yes ___ No

Women:

Are you pregnant? ___ Yes ___ No Due date: _____
Are you nursing? ___ Yes ___ No
Taking birth control pills? ___ Yes ___ No

MEDICATIONS

List of medications you are currently taking and correlating diagnosis

_____
_____
_____

NONE: (PLEASE INITIAL HERE IF NO MEDICATIONS ARE TAKEN AT THIS TIME_____)

ALLERGIES

___ Aspirin
___ Codeine
___ Amoxicillin
___ Penicillin
___ Clindamycin
___ Local Anesthetic
___ Sulfa
___ Latex
___ Other _____
___ NONE

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of any change in my health or medication.

Patient Signature: _____ **Date**: _____