Medical Alert:

FOR OFFICE USE ONLY

Dr. Bahram Mostaghaci & Associates

PID# _____

RESET

Private & Confidential Health History and Personal Information

Welcome to our office. Your overall health is important to us. We strive to treat all patients in a safe and effective manner, therefore we need to ask you some detailed questions related to your general health.

Today's Date ____/____/____ (D / M / Y)

(Dr., Mr., Mrs., Miss., Ms.)

Name _____ (Last / First / Initial)

Date of Birth ____/____/____ (D / M / Y)

Home Phone _____ **Bus** _____ **Cell** _____

Street Address _____ Town/City _____

Postal Code _____ E-mail _____

Occupation _____ Were you referred? Name of person _____

Marital Status _____ Employer _____

Personal Physician _____ Telephone _____

Account and Insurance Information

Person responsible for account? Self____Other _____

Do you have dental insurance? No____ / Yes____ Name of Company _____

Plan # _____ Cert # _____

Medical History

yes	no		Details
☐	☐	Do you have any allergies? (medications, penicillin, latex, hayfever, food)	
☐	☐	Have you ever been advised to take antibiotics prior to a dental visit?	
☐	☐	Are you presently being treated for any medical condition? Specify:	
☐	☐	Have you been a patient in a hospital in the past 2 years?	
☐	☐	Have you had general surgery? Type and date?	
☐	☐	Have you ever had excessive bleeding that needed special treatment?	
☐	☐	Do you have any history of heart disease? (congenital heart disease, chest pains, angina, infective endocarditis, heart attack)	
☐	☐	Do you wear a pacemaker?	
☐	☐	Do you smoke or chew tobacco? How much per day?	
☐	☐	Are you pregnant or breast feeding? If pregnant, when is the expected due date?	

Please list all medications, non-prescription drugs and herbal supplements you are presently taking.

_____

_____

_____

_____

_____

_____

Please continue on the other side, thank you...

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

yes	no		yes	no		yes	no	
☐	☐	high blood pressure	☐	☐	glaucoma	☐	☐	ADD/ADHD
☐	☐	heart attack	☐	☐	HIV/AIDS	☐	☐	autism
☐	☐	heart murmur	☐	☐	hepatitis A / B / C (circle)	☐	☐	nerve disorders
☐	☐	artificial heart valve	☐	☐	rheumatic fever	☐	☐	arthritis
☐	☐	stroke	☐	☐	scarlet fever	☐	☐	osteoporosis
☐	☐	high cholesterol	☐	☐	thyroid condition	☐	☐	artificial joint replacement
☐	☐	anemia	☐	☐	stomach ulcers/acid reflux		(circle)	hip, knee, TMJ, other
☐	☐	asthma	☐	☐	kidney disease	☐	☐	cancer-type/date of diagnosis
☐	☐	respiratory/lung disease	☐	☐	liver disease	☐	☐	_____
☐	☐	tuberculosis	☐	☐	drug/alcohol dependency	☐	☐	auto-immune disease
☐	☐	sinus issues	☐	☐	depression	☐	☐	_____
☐	☐	diabetes: type 1 / type 2	☐	☐	epilepsy/seizures			
			☐	☐	anorexia/bulemia			

DDS Review: _____

Do you have any disease, condition, or illness not listed above? Please specify:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Dental History

When was the last time you saw a dentist? _____

Have you ever had a bad experience at the dentist? _____

How often do you brush and floss your teeth? _____

Have you had your wisdom teeth removed? If so, when? _____

Have you ever had local anesthetic (freezing)? ___ Yes ___ No Any complications? _____

Have you had orthodontic treatment (braces)? If yes, include date of completion. _____

Have you ever had any type of jaw or facial surgery? ___ Yes ___ No _____

Do you wear a grinding appliance or nightguard? _____

Do you have a history of jaw pain? _____

Do you suffer from facial pain, fibromyalgia or trigeminal neuralgia? _____

How would you rate your smile on a scale of 1 to 10? _____

In case of emergency contact: Name _____

Phone (H) _____ (W) _____

Relationship _____

The above medical and dental history is correct and consent for treatment is hereby given.

_____ _____

Patient, Parent or Guardian Date