Medical Alert:

Dr. Bahram Mostaghaci & Associates PID# _____

FOR OFFICE USE ONLY

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.

Dr. Mr. Mrs. Miss. Ms.

Today's Date: ___/___/___ (D M Y)

Name: _____ (Last First Initial)

Date of Birth: ___/___/___ (D M Y)

Home Phone: _____ Bus: _____ Cell: _____

Street Address: _____ Town/City: _____

Postal Code: _____ E-mail: _____

Occupation: _____ Employer: _____

Marital Status: _____ Were you referred? Name of person: _____

Personal Physician: _____ 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, metals, food)	_____
☐	☐	Have you ever taken penicillin / amoxicillin?	_____
☐	☐	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 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.

_____

_____

_____

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

Yes No

- ☐ ☐ High Blood Pressure
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Stroke
- ☐ ☐ High Cholesterol
- ☐ ☐ Anemia
- ☐ ☐ Asthma
- ☐ ☐ Respiratory/Lung Disease
- ☐ ☐ Tuberculosis
- ☐ ☐ Sinus Issues
- ☐ ☐ Diabetes: type 1 type 2

- ☐ ☐ Glaucoma
- ☐ ☐ HIV/AIDS
- ☐ ☐ Hepatitis A B C
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Scarlet Fever
- ☐ ☐ Thyroid Condition
- ☐ ☐ Stomach Ulcers/Acid Reflux
- ☐ ☐ Kidney Disease
- ☐ ☐ Liver Disease
- ☐ ☐ Drug/Alcohol Dependency
- ☐ ☐ Depression
- ☐ ☐ Epilepsy/Seizures
- ☐ ☐ Anorexia/Bulimia

- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Nerve Disorders
- ☐ ☐ Arthritis
- ☐ ☐ Osteoporosis
- ☐ ☐ Artificial Joint Replacement
  Hip Knee TMJ other
- ☐ ☐ Cancer

Type _____

Date of Diagnosis _____

- ☐ ☐ Auto-Immune Disease

_____

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)? _____ No _____ Yes 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? _____ No _____ Yes _____

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? _____

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