avanti dental
advanced dentistry and oral cosmetics

NEW PATIENT INFORMATION FORM

Patient Information (CONFIDENTIAL)

First Name _____ Last Name _____
Address _____ City _____ State ____ Zip _____
What is the best number we can reach you at (Cell, Work, Home?) _____
Secondary Phone Number _____ Email Address _____
Sex ■ F ■ M Date of Birth _____Age _____Marital Status ■ S ■ M ■ D ■ W
Social Security Number _____
Employer _____
Address _____
Who may we thank for referring you (or how did you hear about us?) _____

Responsible Party Information

First Name _____Last Name _____
Relationship to Patient _____
What is the best number we can reach you at (Cell, Work, Home?) _____
Secondary Phone Number _____

Emergency Contact Information

Name _____Phone Number _____
Address _____ Relationship to Patient _____

Insurance Information

Insurance Company _____Group #_____ID # _____
Insured's First Name (subscriber) _____ Last Name _____
Insurance Phone Number _____
Subscriber Date of Birth _____Subscriber SSN# _____

Additional Insurance Information

Do you have additional Insurance ■ Y ■ N
Insurance Company _____Group #_____ID # _____
Insured's First Name (subscriber) _____ Last Name _____
Insurance Phone Number _____
Subscriber Date of Birth _____Subscriber SSN# _____

Payment

Person responsible of account: ■ Patient ■ Guardian ■ Spouse ■ Father ■ Mother
Preferred Payment Method: ■ Cash ■ Check ■ Visa ■ Mastercard ■ Discover

Insurance Authorization

Please read and sign before treatment can be performed. I authorize the dentist to release my information including diagnosis and the records of my treatment or examination rendered to me and/or other health other health practitioners; I hereby assign all medical, dental, and/or surgical benefits to which I am entitled for this service to Dr. Farhoumand. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that my dental insurance carrier may pay less than the actual bill for services, and in that event I am financially responsible for all remaining balance of and/or dependents account within 60 days.

_____
Patient Signature (parent or legal guardian if patient is a minor)

avanti dental
advanced dentistry and oral cosmetics

NEW PATIENT INFORMATION FORM

PATIENT NAME _____ DATE _____

Primary reason for this dental appointment: ■ Examination ■ Emergency ■ Consultation

Dental History

Check one

Do you have a specific dental problem? Describe: _____	■ Yes ■ No
Do you have a dental examination on a routine basis? Last visit: _____	■ Yes ■ No
Do you think you have active decay or gum disease? _____	■ Yes ■ No
Do you brush and floss on a routine basis? Discuss: _____	■ Yes ■ No
Do you gums ever bleed? Discuss: _____	■ Yes ■ No
Do you like your smile? Why? _____	■ Yes ■ No
Does food catch between your teeth? Any loose teeth? _____	■ Yes ■ No
Do you ever have clicking, popping, or discomfort in the jaw joint? Do you clench or grind? ____	■ Yes ■ No
Have your past experiences in the dental office always been positive? _____	■ Yes ■ No
Do you smoke or chew tobacco? _____	■ Yes ■ No
Any sores or growths in your mouth? Discuss: _____	■ Yes ■ No

Medical History

Are you under a physician's care now? Why?_____Who? _____	■ Yes ■ No
Have you ever been hospitalized or had a major operation? Discuss: _____	■ Yes ■ No
Are you taking medications, pills, or drugs? What? _____	■ Yes ■ No
_____	
Are you allergic to any medications or substances? What? _____	■ Yes ■ No

Women (please check): ■ Are you pregnant? ■ Nursing? ■ Taking oral contraceptives?

Do you have or have you ever had any of the following? (Please check)
* If "Yes" to any of the starred conditions, premedication may be required.

■ Acid Reflux	■ Cancer	■ Hepatitis	■ Rheumatic Fever *
■ AIDS / HIV Positive	■ Diabetes	■ High Blood Pressure	■ Rheumatism
■ Allergies (medications)	■ Epilepsy or Seizures	■ Hives or Rash	■ Sinus Trouble
■ Allergies (pollen/dust)	■ Glaucoma	■ Kidney Problem	■ Stomach Problem
■ Alzheimer Disease	■ Head Injuries	■ Low Blood Pressure	■ Stroke
■ Anemia	■ Heart Attack	■ Lung Disease	■ Thyroid Disease
■ Artificial Heart Valve *	■ Heart Disease	■ Mitral Valve Prolapse *	■ Tuberculosis (TB)
■ Artificial Joint *	■ Heart Murmur *	■ Need Premedication?	■ Ulcers
■ Arthritis / Gout	■ Heart Pace Maker	■ Nervousness	■ Venereal Disease
■ Asthma	■ Heart Surgery	■ Psychiatric Care	Other: _____

Have you ever had any serious illness not checked above? Discuss: _____ ■ Yes ■ No

Does your family have any of the following medical history? (Please check)

■ Diabetes ■ Heart Disease ■ Gum Disease ■ Cancer

Do you wish to talk to the dentist privately about any problem? _____ ■ Yes ■ No

_____ _____
Patient Signature (parent or legal guardian if patient is a minor) Date

_____(DDS) _____
Reviewed by Date