Dr. Edmond Ghiabi, Periodontist Dr. Negin Ghiabi, Pediatric Dentist



## PATIENT REGISTRATION

Patient name	Date of birth (d/m/y)			
Mailing address				
Phone # homemobile Emergency contact name & phone #	Email			
Name of person responsible for account				
Health card #				
Primary Insurance Coverage				
Do you have dental insurance?	□yes □no			
Insurance company	Employer			
Policyholder name	Policyholder DOB (d/m/y)			
Group/Contract/Policy#	Employee #			
Secondary Insurance Coverage				
Do you have secondary dental insurance?	□yes □no			
Insurance company	Employer			
Policyholder name				
Group/Contract/Policy#	Employee #			
How did you hear about us? □My dentist	□Internet □Other			
Patient's (or Guardian's) Signature:				
Date:				

## **MEDICAL HISTORY**

## PLEASE ANSWER THE FOLLOWING QUESTIONS ACCURATELY. YOUR RESPONSES WILL REMAIN STRICTLY CONFIDENTIAL.

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		Yes	No
1.	Are you under the care of a physician for any medical conditions?		
2.	Have you had an annual check-up within the past 12 months?		
3.	Physician's name		
	Physician's phone number		
4.	Have you been hospitalized in the past 2 years?		
5.	Are you currently taking any medications prescribed by your physician?  If yes, please list them below:		
6.	Are you allergic to any of these medications?  O Penicillin O Sulfa drugs O Codeine O Aspirin O Iodine O Local anesthetics O Other:		
7.	Have you experienced excessive bleeding or bruising from a cut before?		
8.	Do you smoke?  If yes, how much and for how long?		
9.	Do you use recreational drugs?  If yes, how often and for how long?		

10.	Do you have any of the following conditions?	Yes	No		Yes	No
	AIDS			High blood pressure		
	Anemia			Jaundice		
	Angina pectoris			Kidney disease		
	Arthritis			Liver disease		
	Artificial heart valves			Malignant hyperthermia		
	Artificial joints (hip/knee)			Mental disorders (specify)		
	Asthma					
	Bronchitis			Mitral valve prolapse		
	Cancer (specify)			Organ transplant (specify)		
	Diabetes (specify)			Radiation/ chemotherapy		
	Emphysema/bronchitis			Rheumatic/scarlet fever		
	Epilepsy/ seizures			Sickle cell disease		
	Glaucoma			Sinus trouble		
	Heart disease/ attack			Stomach/ intestinal problems		
	Heart murmur			Stroke		
	Heart pacemaker			Thyroid disease (specify)		
	Heart surgery			Tuberculosis		
	Hepatitis (A, B, or C)			Venereal disease		
	Herpes			Other:		
11.	1. Is there anything else about your health we need to know?			need to know?		
12.	WOMEN ONLY Are you taking birth control pills?					
13.	Are you pregnant? If yes, how far along?					

## **DENTAL HISTORY**

1.	How frequently do you see a dentist?   □Annually □Emergency	care only	□Bi-anr	-			
2.	When was your last dental visit? L	•					
			7	Yes	No		
3.	Have you ever seen a periodontist before?						
	If yes, when and for what reason?						
4.	Do you brush your teeth at least twice a day?						
5.	Do you floss your teeth at least once a day?						
6.	Do you use any other devices to clean your teeth?						
7.	Are your teeth sensitive to cold?						
8.	Do you have a history of gum disease?						
9.	Do you have a family history of gum disease?						
10.	0. Do your gums bleed when brushing or flossing your teeth?						
11.	Do you have bad breath or bad taste in your mouth?						
12.	2. Do your jaws crack or pop when you open or close your mouth?						
13.	Do you grind or clench your teeth?						
14.	Do you have any loose teeth?						
15.	6. Have you ever had a reaction to local anesthetics (freezing)?						
16.	6. Have you ever had excessive bleeding during or after a tooth extraction?						
17.	Are you usually anxious before or during a dental visit?  If yes, please rate your anxiety:  0 1 2 3 4 5 6 7 8 9 10  (not anxious extremely anxious)						
I consent to dental examination by Dr. Edmond Ghiabi, who may request more x-rays &/or diagnostic models to make accurate diagnosis of my condition and to plan for my treatment.							
Patient's (or Guardian's) Name:							
Patient's (or Guardian's) Signature:							
Dat	Date:						