CONGRESS DENTAL GROUP

Welcome!

ARLINGTON DENTAL

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as possible. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date:____________________ Whom may we thank for referring you? _________________________________

Name: _________________________ Home Phone: (____)______________

Cell Phone: (____)________________ Work Phone: (____)______________

Address: ____
City: ____________________ State: _____ Zip: ___________

Patient Occupation: ____
Employer/School Address: ____

Spouse's Name: __________________ Work Phone: (____)______________
Spouse's Occupation: ____
Spouse's Birth date: _______________ Spouse's Age: _________

In case of emergency who should be notified? __________________________

Social Security #:_________-_______-______________

Birth date: ________________ Age: _________ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single
Email: ____

Patient Employer/School:________________________
Employer/School Phone: (____)____________________

Spouse's Social Security #: _________-_______-_______
Spouse's Employer/School:________________________
Patient Employer/School:_________________________

Phone: (____)_________Alt Phone: (____)_________

Dental Insurance Information

Insurance Company Name: __________________________________
Who is the subscriber for this account? ________________________
What is the subscriber's birth date? ________________

Group #: ____
What is their relationship to the patient? _________________________

Is the patient covered by additional insurance? ☐ Yes ☐ No
Insurance Company Name: __________________________________
Who is the subscriber for this account? ________________________
What is the subscriber's birth date? ___________________________

Group #: ____
What is their relationship to the patient? _________________________

Assignment and Release

I certify that I, and/or my dependents(s), have insurance coverage with ___________________________________ (name of insurance company) and assign directly to **Bob Pajoohi DMD PC / Congress Dental Group** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ (signature of patient, parent, guardian or personal representative)

__________________________________ (relationship to patient)

____ (printed name of patient, parent, guardian or personal representative)

__________________________________ (date)

Today's Visit

What is the reason for today's visit? ____
What are your present dental concerns?____
Who was your previous dentist? ____ City: ____________________ State: ______
When was your last dental visit? ________________ last dental x-rays? __________________ last dental cleaning? ___________________

Have you avoided regular dental care in the past? If so, why? ____
What are your dental expectations? ____
How would your rate your previous overall experiences with dental care? ☐ Positive ☐ Neutral ☐ Negative

How often do you brush? ____ How often do you floss? ________________________________
Do you use any other cleaning aid? How often? ____
Are you happy with the appearance of your teeth? ☐ Yes ☐ No Are you happy with the appearance of your gums? ☐ Yes ☐ No
Would you like your teeth to be whiter? ☐ Yes ☐ No Would you like your teeth to be straighter? ☐ Yes ☐ No

Dental History

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

Active decay	☐ Yes ☐ No	Food collection between teeth	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Bad breath	☐ Yes ☐ No	Swollen or tender gums	☐ Yes ☐ No	Mouth sores or growths	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Periodontal (gum) treatment	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Loose teeth	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Broken fillings	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No
Clicking or popping jaw	☐ Yes ☐ No	Pain from brushing	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Pain around the ears	☐ Yes ☐ No	Chew on one side of mouth	☐ Yes ☐ No
Gum disease	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No	Cigarette, pipe, or cigar smoking	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No		
Foreign Objects	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No		

Health History

Who is your current physician? ____ Date of last visit: _______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Please place a mark on "yes" or "no" to indicate if you have experienced any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Respiratory disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Sinus trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart problems	☐ Yes ☐ No	Skin rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis type ____	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding abnormally		Herpes	☐ Yes ☐ No	Special diet	☐ Yes ☐ No
with extractions or surgery	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Swollen feet or ankles	☐ Yes ☐ No
Blood disease	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen neck glands	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaw pain	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No
Chemical dependency	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Circulatory problems	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No	Tumor	
Congenital heart lesions	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No	or growth on head or neck	☐ Yes ☐ No
Cortisone treatments	☐ Yes ☐ No	Nervous problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Persistent or bloody cough	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No	Venereal disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Unexplained weight loss	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Radiation	☐ Yes ☐ No		

Do you wear contact lenses? ☐ Yes ☐ No
Is there anything else we should know? ____

WOMEN - Are you pregnant? ☐ Yes ☐ No Due date: _________________ Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis. (If none, please write "none.") ____
____

Allergies

Aspirin	Iodine	Penicillin
Barbiturates (sleeping pills)	Latex	Sulfa
Codeine	Local anesthetic	

Other? (If none, please write "none.") ____

By my signature below, I certify that I have read each of the above questions and that all of the information herein is correct to the best of my knowledge. I hereby certify that I have answered each of these questions truthfully, accurately and as completely as possible.

____ (signature of patient, parent, guardian or personal representative)

__________________________________ (relationship to patient)

____ (printed name of patient, parent, guardian or personal representative)

__________________________________ (date)