Name _____ Address _____

City _____ State ___ Zipcode _____ Home Phone _____ Work Phone _____

Date of Birth _____ Sex ___ Height _____ Weight _____ Occupation _____

Soc Sec # _____ Single _____ Married _____ Name of Spouse _____

Closest Relative _____ Phone _____

Eligible Member Information

Employee Soc Sec # _____ Employee Name _____ Group # _____

Where Employed _____ Employer Address _____

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

YES	NO	
☐	☐	1. Are you in good health?
☐	☐	2. Has there been any change in your general health within the past year?
		3. My last physical exam was on _____
☐	☐	4. Are you now under the care of a physician? If so, what is the condition being treated? _____ Name of Physician _____ Physician's Address _____ Phone Number _____
☐	☐	5. Have you had any serious illness or operation? If so, what was the illness or operation? _____
☐	☐	6. Have you been hospitalized or had a serious illness within the past five (5) years? If so, what was the problem? _____
		7. Do you have or have you had any of the following diseases or problems?
☐	☐	a. Damaged heart valves or artificial heart valves, including heart murmur
☐	☐	b. Congenital heart lesions
☐	☐	c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)
☐	☐	1. Do you have pain in your chest upon exertion?
☐	☐	2. Are you ever short of breath after mild exercise?
☐	☐	3. Do your ankles swell?
☐	☐	4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep?
☐	☐	5. Do you have a cardiac pacemaker?
☐	☐	d. Allergy If so, what are you allergic to? _____
☐	☐	e. Sinus trouble
☐	☐	f. Asthma or hay fever
☐	☐	g. Hives or a skin rash
☐	☐	h. Fainting spells or seizures
☐	☐	i. Diabetes
☐	☐	1. Do you have to urinate more than six times a day?
☐	☐	2. Are you thirsty much of the time?
☐	☐	3. Does your mouth frequently become dry?
☐	☐	j. Hepatitis, jaundice, or liver disease
☐	☐	k. Arthritis
☐	☐	l. Inflammatory rheumatism (painful swollen joints)
☐	☐	m. Stomach ulcers
☐	☐	n. Kidney trouble
☐	☐	o. Tuberculosis
☐	☐	p. Do you have a persistent cough or cough up blood?
☐	☐	q. Low blood pressure
☐	☐	r. Venereal Disease
☐	☐	s. Epilepsy
☐	☐	t. Psychiatric problems
☐	☐	u. Cancer
☐	☐	v. AIDS or other immunosuppressive disorders
☐	☐	w. Other: _____
☐	☐	8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?
☐	☐	a. Do you bruise easily?
☐	☐	b. Have you ever required a blood transfusion? If so, explain the circumstances _____
☐	☐	9. Do you have any blood disorder such as anemia?
☐	☐	10. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?
☐	☐	11. Are you taking any drug or medicine? If so, what? _____

(Continued on other side)

YES	NO	
		12. Are you taking any of the following:
☐	☐	a. Antibiotics or sulfa drugs
☐	☐	b. Anticoagulants (blood thinners)
☐	☐	c. Medicine for high blood pressure
☐	☐	d. Cortisone (steroids)
☐	☐	e. Tranquilizers
☐	☐	f. Antihistamines
☐	☐	g. Aspirin
☐	☐	h. Insulin, tolbutamide (Orinase), or similar drug
☐	☐	i. Digitalis or drugs for heart trouble
☐	☐	j. Nitroglycerin
☐	☐	k. Oral contraceptives or other hormonal therapy
☐	☐	l. Other
		13. Are you allergic or have you reacted adversely to:
☐	☐	a. Local anesthetics
☐	☐	b. Penicillin or other antibiotics
☐	☐	c. Sulfa drugs
☐	☐	d. Barbiturates, sedatives, or sleeping pills
☐	☐	e. Aspirin
☐	☐	f. Iodine
☐	☐	g. Codeine or other narcotics
☐	☐	h. Other _____

14. What is your chief dental complaint: _____

_____

_____

☐	☐	15. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____
☐	☐	16. Do you have any disease, condition, or problem not listed above that you think I should know about? If so, explain _____
☐	☐	17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
☐	☐	18. Are you wearing removable dental appliances?

WOMEN

☐	☐	19. Are you pregnant?
☐	☐	20. Do you have any problems associated with your menstrual period?
☐	☐	21. Are you nursing?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient Date

_____ _____

Signature of Dentist Date

General Consent

I hereby authorize **FARROKH ERFAN, D.D.S.** to employ such treatments and technical procedures as may be deemed necessary or advisable in the dental treatment of _____

I understand that this authorization will cover all aspects of routine dental care including administration of x-rays, photographic records, local anesthetics, sedative drugs, and treatments including preventive and restorative dentistry (cleaning and scaling of teeth, fillings, root canal treatments, orthodontic care, and the fitting of dentures, crowns, and bridges), and minor surgical procedures (extractions and gum surgery).

I understand that this authorization shall remain in full effect for the present visit as well as for subsequent visits during the course of treatment. All of my questions have been answered.

Signature of Patient: _____ Date: _____

(If a minor, parent or guardian must sign)

Witness: _____