Mr. Mrs. Ms. Dr.

Name _____ Soc. Sec _____ Driver's License#_____

Home Address _____
(Street) (Apt. #) (City) (Zip)

Home Phone#_____ Work Phone#_____ Cell# _____

Age_____ Birth Date_____Marital Status: S M W D Sep

Employed By _____ Business Address _____

Position _____ How Long Held? _____

Spouse's Name_____ Employed By_____ Position_____

Spouse's Business Address_____ Phone_____

Party Responsible For This Account_____ Phone_____

Someone To Contact In Case Of An Emergency (Not Living With You)_____

Address_____ Phone_____

School Children Attend_____

Whom May We Thank For Referring You To Our Office?_____

My Reason To Make This Appointment Is _____

DENTAL INSURANCE INFORMATION

(Primary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address _____

Insured's Employer_____

Insured's Soc. Sec. # _____

Group #_____

Insured Birth Date_____

(Secondary Carrier)

Insured's Name _____

Insurance Co. _____

Insurance Co. Address_____

Insured's Employer_____

Insured's Soc. Sec. #_____

Group #_____

Insured Birth Date_____

FOR YOUR INFORMATION- PLEASE READ OUR OFFICE POLICY: Please take a few moments to read and acknowledge this: FIXED OR REMOVABLE PROSTHETICS, such as dentures , crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due payable when the initial impression is made.

AS A COURTESY TO YOU. Our office will, if necessary, accept 50% of this amount at the time of the impression. The balance must be paid at the time of permanent seating or no more than 30 DAYS from date of impression, WHICHEVER COMES FIRST, unless prior arrangements have been made with our office manager. We accept insurance for a payment, however, you must pay your portion at the time services are rendered.

PROSTHETICS MUST BE SEATED IN A TIMELY MANNER TO INSURE YOUR COMFORT, AND PROPER FIT. If you fail to have your prosthetics seated within 60 days from date of impression, and a second impression must be made, you will be charged an additional amount of one-half of our current charge for such procedure.

WE OFFER YOU QUALITY DENTAL CARE, ECONOMICALLY PRICED, and we want you to feel comfortable with all of our treatments and policies. Please feel most welcome to contact our office manager for any questions you may have. ACKNOWLEDGEMENT: I have read and understand above policies: I also understand that whether or not dental insurance provides for partial or full payment, I am ultimately responsible for fees charged.

Signature

Physician's Name_____ Phone #_____

Date of your last Physical Exam _____

Dentists Name _____ Phone #_____

Date of your last Dental Exam

CIRCLE

1. Are you in good health? YES NO
2. Have you ever been a patient in a hospital or had any serious illness?
   If so, Please explain YES NO
3. Are you now or have been under the care of a physician during the past two years? YES NO
   If so, what was the condition you were treated for? YES NO
4. Do you now take or have you taken any kind of medicine or drugs during the past year? YES NO
   If so, what?
5. Are you allergic to or ever experienced any ill effect from Novocain, Penicillin, YES NO
   Tranquilizers or any other drugs?
   If so, please explain
6. Circle the name of the following which you have had of have:

AIDS/HIV*	Alcohol/ Drug Addiction	Cancer or Tumor
Arthritis	Tuberculosis (TB)	Abnormal Bleeding/ Hemophilia
Rheumatic Fever	Diabetes	Severe Infections
Heart Trouble/Heart Surgery	Herpes/Fever Blisters	Severe Headaches
Heart Murmur	Kidney or Bladder Trouble	Epilepsy
High or Low Blood Pressure	Anemia	Thyroid Disease
Heart Pacemaker	Lung Disease	Glaucoma
Heart Attack/ Stroke	Pneumonia	Radiation (X-Ray) Treatment
Shortness of Breath	Venereal Disease	Fainting Tendency/Epilepsy/Seizures
Asthma or Hay Fever	Blood Disease/ Blood Transfusion	Chemotherapy
Sinus Trouble	Liver Disease	Psychiatric Treatment
Hepatitis or Jaundice	Slow Healing	Artificial Valves/Joints/ Bones

Notes

7. Have you had a serious illness not listed above? YES NO
   If so, please explain
8. Women Only: Are you pregnant? YES NO
   Are you breast feeding? YES NO
   Are you taking any medication routinely (Birth Control, Hormones, etc.) YES NO
9. Do you wear PARTIALS or DENTURES? YES NO
   If so, are you happy with them? YES NO
10. Do your gums BLEED, or feel TENDER? YES NO
11. Would you CHANGE YOUR SMILE if you could? YES NO

12. Are you UNHAPPY with your APPEARANCE with your teeth? YES NO
13. Do you have FEARS of dental treatment? YES NO
14. Are you aware of GRINDING or CLENCHING your teeth? YES NO
15. Do you have sensitive teeth? YES NO

The above is true to the best of my knowledge. If I ever have any change in my health or if my medicines change, I will inform Dr. Nouri at the next appointment without fail.

Today's Date_____ Signature_____

MEDICAL HISTORY UPDATE

1. Date:_____ Comments:_____ Signature:_____
2. Date:_____ Comments:_____ Signature:_____
3. Date:_____ Comments:_____ Signature:_____