F. Michael Firouzian, DDS ~ Health History Form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:

Last First Middle Sex M F DOB

Home Address City State Zip

E-mail: Phone Numbers: Home: Work Cell:

How did you hear about us?

Dental Insurance *Please mark (X) to indicate your responses to the following questions.*

Subscriber Name _____ Social Security _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone# _____ Group # _____

Relation to Patient _____ Insurance ID # _____

Subscriber Name _____ Social Security _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone# _____ Group # _____

Relation to Patient _____ Insurance ID # _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address : _____

_____

Telephone: _____

Insurance Authorization Statement (Sign and Date) I hereby authorize payment directly to the Dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize Dr. Firouzian to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Signature:_____ Date: _____

Treatment and Authorization Form (Sign and Date): I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthetic and other medication as indicated.

Signature: _____ Date: _____

Dental Information *Please mark (X) to indicate your responses to the following questions.*

Have you experienced any of the following: YES NO

Bleeding gums when you brush or floss? _____

Tooth sensitivity to cold, hot, sweets or pressure? _____

Food or floss catching between your teeth? _____

Dry mouth? _____

Sores or ulcers in your mouth? _____

Serious injury to your head or mouth? _____

Do you:

Have earaches or neck pains? _____

Have any clicking, popping or discomfort in the jaw? _____

Brux or grind your teeth? _____

Get headaches frequently? _____

Wear dentures or partials? _____

Have you ever had any of the following: YES NO

Periodontal (gum) treatments? _____

Orthodontic (braces) treatment? _____

Problems associated with previous dental treatment? _____

If yes please explain

Are you currently experiencing dental pain or discomfort? _____

If yes please explain

Date of your last dental exam:

What was done at that time?

Date of last dental x-rays:

Where were they done?

What is the reason for your dental visit today?

Medical Information (cont.) *Please mark (X) to indicate your responses to the following questions*

Are you in good health? YES NO

Any change in your general health in the past year? YES NO
If yes please explain

Date of last physical exam: _____

Who are your doctors?

Primary Care Provider _____

Other _____ Specialty _____

Other _____ Specialty _____

Any serious illness or hospitalization in past 5 years? YES NO
If yes please explain

Are you taking any prescription medications? YES NO
Please list

Are you taking any over the counter medications? YES NO
Please list

Are you taking any supplements, vitamins or herbal preparations? YES NO
Please list

Are you allergic to or have you had a reaction to:

	YES	NO
Local anesthetics		
Aspirin		
Penicillin or other antibiotics		
Codeine or other narcotics		
Other Medications (specify		
Metals		
Latex (rubber)		
Food (specify)		
Hay fever/seasonal		
Animals		
Other (specify		

Are you Pregnant? YES NO

Do you use tobacco? (smoking, snuff, chew) _____
Do you drink alcoholic beverages _____
If yes, how much do you typically drink in a week? _____

Have you ever had any of the following: YES NO

Artificial joint replacement? (finger, hip, knee, elbow) _____
Artificial (prosthetic) heart valve? _____
Infective carditis? _____
Damaged valves in transplanted heart? _____
Congenital heart disease? _____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? YES NO

Name of physician or dentist making that recommendation: _____

Please mark (X) to indicate whether you have or have had any of the following diseases or conditions

	YES	NO
Angina		
Arrhythmia		
Cardiovascular disease		
Chest pain on exertion		
Congenital heart defect		
Congestive heart failure		
Damaged heart valves		
Heart attack		
Heart murmur		
High blood pressure		
Low blood pressure		
Pacemaker		
Stroke		
Asthma		
Bronchitis/Emphysema		
Tuberculosis		
Diabetes		
Type I or Type II		
Arthritis		
Osteo or RA		
Autoimmune disease		
Chronic pain		
Chronic fatigue		
Osteoporosis		

	YES	NO
Abnormal bleeding		
Anemia		
AIDS or HIV infection		
Sexually transmitted disease		
Recurrent infections		
type of infxn		
Thyroid problems		
Glaucoma		
Other vision or hearing problem		
Eating disorder		
Malnutrition		
Gastrointestinal disease		
Ulcers / Colitis		
Hepatitis, jaundice or liver disease		
Kidney problems		
Excessive urination		
Cancer		
Type		
Chemotherapy?		
Radiation?		
Severe or rapid weight loss		

	YES	NO
Epilepsy		
Seizures		
Neurological disorders		
Depression		
Anxiety		
Other mental health condition		
specify		
Sinus Trouble		
Night Sweats		
Severe Headaches		
GE Reflux (heartburn)		
Tonsillitis		
Snoring		
Stop breathing when sleeping		
Overweight		
High blood pressure		
Daytime sleepiness		
Sleep Disorder		
Specify		
Chemical Dependency		
Other		

Do you have any disease, condition, or problem not listed above that you think I should know about? YES NO
Please explain:

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____