

Personal Information

Name: _____
 Home Phone: () _____ - _____
 Cell Phone: () _____ - _____
 Address: _____
 City _____ State _____ Zip _____
 Email: _____
 Employer: _____
 Business Phone: () _____ - _____
 S.S.Number: _____ - _____ - _____ D.O.B.: ____/____/____
 CA License or ID #: _____
 Height: _____ Weight: _____ Sex: _____
 Emergency contact: _____
 Relationship to you: _____ Phone: _____
 How did you find us? _____

Insurance Information

Insured's Name (Yourself, spouse, other): _____

 Relationship to Insured: Self Spouse Child Other
 Insured's DOB: ____/____/____
 Insured SSN: _____ - _____ - _____
 Insurance Company: _____
 Group Number: _____
 Employer's Name: _____

If you have dual coverage, please give information to front office staff.

Medical Information

Are you in good health?.....Y / N
 Do you have a physician?.....Y / N
 Physician name: _____
 Date of your last physical: ____/____/____
 Physician Phone: () _____ - _____
 Physician Address: _____
 City _____ State _____ Zip _____
 Are you under the care of a physician now?
 If so, for what?

 Have you ever been ill, hospitalized, or had an illness in
 the last five years?.....Y / N
 If so, for what? _____

Do you have, or have you had, any of the following:

Damaged heart valves/ artificial heart valves.....Y / N
 Mitral Valve Prolapse.....Y / N
 Rheumatic Fever/Rheumatic Heart Disease.....Y / N
 Endocarditis.....Y / N
 Congenital Heart Lesions.....Y / N
 Heart Murmurs (functional or organic).....Y / N
 Angina Pectoris.....Y / N
 Heart Failure.....Y / N
 Hypertension (High Blood Pressure).....Y / N
 Arteriosclerosis or coronary insufficiency.....Y / N
 Coronary occlusion.....Y / N
 Do your ankles swell during the day?.....Y / N
 Chest pain upon exertion.....Y / N
 Are you short of breath after mild exercise?.....Y / N
 Do you get short of breath when you lie down?.....Y / N
 A Pacemaker.....Y / N
 Steroid (Cortisone) Therapy.....Y / N
 Allergies.....Y / N
 Medication allergies: _____
 Sinus Trouble.....Y / N
 Asthma.....Y / N
 Hives or Skin Rash.....Y / N
 Fever Blisters or Cold Sores.....Y / N
 Fainting Spells or Seizures.....Y / N
 Diabetes (type I or type II).....Y / N
 Thyroid problems.....Y / N
 Are you always thirsty, urinate a lot, or have dry mouth?.....Y / N
 Hepatitis, jaundice, or liver disease.....Y / N
 Alcohol or drug abuse.....Y / N
 Arthritis or Lupus.....Y / N
 Inflammatory rheumatism.....Y / N
 Stomach ulcers.....Y / N
 Kidney trouble.....Y / N
 Cancer.....Y / N
 Chemotherapy or Radiation Therapy.....Y / N
 Compromised Immune System.....Y / N
 HIV / AIDS.....Y / N
 Tuberculosis.....Y / N
 A persistent cough or cough up blood?.....Y / N
 Emphysema.....Y / N
 Prosthetic hip or joint, implants, bone plates or screws.....Y / N
 A bleeding disorder.....Y / N
 Anemia or Hemophilia.....Y / N
 Leukemia, or lymphoma.....Y / N
 Blood transfusion? When and why?.....Y / N
 Bleeding problem after having a tooth pulled.....Y / N
 Have you ever had any condition not listed above?
 If so, please list: _____
 List of current medications:

For women only

Are you pregnant?.....Y / N
 Are you nursing?.....Y / N
 Are you on birth control medication?.....Y / N

Dental Information

Date of last dental exam: ____/____/____

What was done at that time? _____

Former Dentist name: _____

City, State: _____

Please answer yes or no:

I am concerned about the appearance of my teeth or smile.....Y / N

I am concerned about the whiteness or lack of whiteness of one or more of my teeth.....Y / N

I am concerned about the position or angle of one or more of my teeth.....Y / N

In social situations, I am sometimes embarrassed by my teeth or my smile.....Y / N

There are some things about my upper front teeth that I would like to change.....Y / N

There are some things about my lower front teeth I would like to change.....Y / N

I have old fillings or existing dental work that I am no longer satisfied with.....Y / N

I am missing one or more of my teeth and would like to fix the space(s).....Y / N

Please answer:

Are your teeth sensitive to: (please circle)
heat cold sweets pressure

Do your gums bleed when you:(please circle)
brush floss both

Do you experience jaw **clicking** or **pain**?.....Y / N

Do you think you **grind** or **clench** your teeth?.....Y / N

Do you have **sores** or **lumps** in/around your mouth?.....Y / N

Do you experience fear or anxiety at the dentist?.....Y / N

Do you have problems sleeping?.....Y / N

Do you snore?.....Y / N

Do you wake yourself up in the middle of the night?.....Y / N

Do you wake up in the morning feeling fatigued?.....Y / N

Do you think you have sleep apnea?.....Y / N

Do you have a C-PAP?.....Y / N

Please initial the following:

___ I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

___ I hereby authorize the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

___ I acknowledge that I received The Dental Material Fact Sheet, developed by the State of California. I acknowledge that I was given a copy and that I can always access this fact sheet at www.estheticdentistry.net/factsheet.pdf.

___ I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use all appropriate medication and therapy indicated by such treatment.

___ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to choose and employ such anesthetics as deemed fit to provide recommended treatment.

___ I hereby authorize payment directly to Armen Mirzayan, DDS, Inc (Esthetic Dentistry Dental Group) of the dental benefits otherwise payable to me.

___ Armen Mirzayan, DDS, Inc. (Esthetic Dentistry Dental Group) is authorized to provide any insurance company(s), claims administrator(s), and consulting health professionals, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of the coverage of the policy or contract, in force on this date only, or for two years, whichever is shorter. I know that I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

___ I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account, in addition to any collection charges.

___ I understand that it is my responsibility to inform your office of any changes to the information contained in this form.

Signature: _____

Today's Date: ____/____/____

Parent or Responsible Party: _____

Relationship to Patient: _____

Reviewed by Front Desk: _____

Reviewed by Doctor: _____