Dr. Anoush Yessaian

Welcome!

PATIENT

Name_____ Age_____ Birthday_____
Last First Middle

Who may we thank for referring you?_____

If patient is a minor, give parent's or guardian name_____Relationship_____

☐ ☐ ☐ ☐ ☐ ☐

MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED

Address_____City_____State__Zip_____
S.S#_____D.L#_____Cell Phone_____

Employer_____Position_____ Buss. Phone_____
Buss. Address_____City_____State____Zip_____
Who should be notified in case of an emergency_____Phone_____
Email_____ Best way to reach you_____
Purpose of this appointment_____

SPOUSE

Name_____Age_____Birthday_____
Employer_____Position_____Buss. Phone_____
Buss. Address_____City_____State____Zip_____
S.S#_____D.L#_____Cell Phone_____

INSURANCE INFORMATION Do you have insurance? ☐ Yes ☐ No

If yes, complete the following:

Name of insured_____S.S#_____Relationship_____
Insurance Company_____Group No._____

Is patient covered by other insurance? Yes ☐ No ☐ **If yes, complete the following:**
Name of insured_____S.S#_____Relationship_____
Insurance Company_____Group No._____

Terms & Condition

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be the determined before treatment. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time services are performed. I understand the dental services furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I understand that the fee estimate listed for the Dental case can only be extended for a period of six months from the date of patient's examination. In consideration of the professional services rendered to me, or at my request, by the doctor and/or his staff, I agree to pay therefore, the reasonable value of said service to doctor or his assignee at the time set services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing within the time for payment there of. Additionally, I agree that a waiver for any breach of any term or condition here under shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in search proceeding shall be entitled to recover all cost incurred including reasonable attorney's fees. I ground my permission to you, or assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to their content.

Signature_____Date_____

Health Questionnaire

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care. Please answer each question. Bubble in the boxes, Y for yes, and N for no.

MEDICAL HISTORY

1. Are you having any dental problems at this time?_____Yes No
2. Are you now under the care of a physician?_____Yes No

If so, provide name of physician_____Phone_____
If so, what is the condition being treated?
_____

3. Have you ever had any serious illness, operation, or been hospitalized?_____Yes No

If so, what illness, operation, or why were you hospitalized?_____
Are you taking any medicine/recreational drugs (cocaine, marijuana, etc.)___ Yes No If so, what? _____

4. Have you ever been pre-medicated with antibiotics for your dental treatment?_____Yes No
5. Are you allergic to the following drugs?

☐ icillin ☐ rythromycin ☐ racycline S☐a Drug A☐irin C☐eine I☐x

6. Have you ever had excessive bleeding requiring special treatment? _____ Yes No
7. Do you have any of the following? Please bubble in the box

	Y	N		Y	N		Y	N		Y	N
Congenital Heart Lesion			Tuberculosis			Blood Disease			Rheumatism		
Heart Disease/Attack			Liver Disease			Anemia			Cortisone Medication		
Heart Surgery/Failure			Leukemia			Ulcers			Psychiatric Treatment		
Artificial Valve/Pacemaker			Kidney Trouble			Blood Transfusion			Nervous Disorder		
Heart Murmur			Thyroid Disease			Drug Addiction			Head injuries		
Chest Pain			Glaucoma			Herpes			Mental disorder		
High Blood pressure			Respiratory Disease			Syphilis-Gonorrhea			Cerebral palsy		
Rheumatic Fever			Emphysema			HIV-positive			Epilepsy/Seizure		
Stroke			Shortness of breath			AIDS			Fainting spells		
Artificial Prosthesis/Joint			Asthma			Difficulty Swallowing			Tumors/Growths		
Diabetes			Hay Fever			Pain in Jaw joint			Cancer		
Hepatitis A-B-C			Allergies/Hives			Arthritis			Chemotherapy / Cobalt Treatment		

8. Do you have a disease, condition that's not listed?_____Yes No If so, what?_____
9. Have you taken FEN-PHEN or REDUX or on a special diet?_____ Yes No
10. Do your ankles swell during the day?_____ Yes No
11. Do you use more than two pillows to sleep?_____ Yes No
12. Have you lost or gained more than 10 pounds in the last 6 months?_____ Yes No
13. (Women) Are you pregnant?_____ Yes No If so, how many months?_____
14. (Women) Are you taking birth control pills? _____ Yes No

DENTAL HISTORY

1. Have you had a bad experience in the dental office?_____ Yes No
2. Does dental treatment make you nervous?_____ Yes No
3. How long since your treatment and cleaning?)_____
4. How long since your last full mouth X-Ray?_____
5. Do your gums bleed?_____
6. Reason for seeking dental treatment?_____
7. How do you feel about a healthy mouth?_____
8. How do you feel about the appearance of your teeth and smile?_____
9. If you could change anything about your smile what would you change?_____

To the best of my knowledge, all of the preceding information is true and correct. If I ever have any changes in my health or if my medications change, I will make sure to inform the doctor at my next appointment.

Reviewed by DO NOT WRITE HERE

Date_____ Signature_____ **Year 1** **Year 2** **Year 3**

Year 2 _____ **Date** _____ _____ _____

Date_____ Signature_____

Year 3

Date_____ Signature_____

Changes in Health_____

Health history must be updated every 6 months

Year 1	BP	___/____	___/____	____/____
_____	Pulse	_____	_____	_____
Year 2	BP	_____	_____	_____
_____	Temp	_____	_____	_____
Year 3	By	_____	_____	_____