A. Rassouli, D.D.S. & R. Jay Rassouli, D.D.S.

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care.
To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

SS#/SIN _____
Date _____

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov._____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
If Student, Name of School/College _____ City _____ State/Prov._____ ☐ Full Time ☐ Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Address _____ City _____ State/Prov._____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom may we thank for referring you? _____
Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this person currently a patient in our office? ☐ Yes ☐ No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
☐ Cash Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy. **We do not accept checks.**

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov._____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov._____ Zip/P.C. _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov._____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov._____ Zip/P.C. _____

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Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking?	☐	☐
4. Have you had a serious head, neck or jaw injury?	☐	☐
5. Have you ever taken Fen-Phen/Redux?	☐	☐
6. Have you ever taken Fosamax, Boniva, Actonel or any osteoporosis/cancer medications containing bisphosphonates?	☐	☐
7. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	☐	☐
8. Do you use tobacco?	☐	☐
9. Do you use controlled substances?	☐	☐

	Yes	No
11. Are you wearing contact lenses?	☐	☐
12. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)		
13. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	☐	☐
14. Women Only:		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

10. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV Positive	☐	☐	Cortisone Medicine	☐	☐	Heart Trouble/Disease	☐	☐	Recent Weight Loss	☐	☐
Alzheimer's Disease	☐	☐	Diabetes	☐	☐	Hemophilia	☐	☐	Renal Dialysis	☐	☐
Anaphylaxis	☐	☐	Drug Addiction	☐	☐	Hepatitis A	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Easily Winded	☐	☐	Hepatitis B or C	☐	☐	Rheumatism	☐	☐
Angina	☐	☐	Emphysema	☐	☐	Herpes	☐	☐	Scarlet Fever	☐	☐
Arthritis/Gout	☐	☐	Epilepsy or Seizures	☐	☐	High Blood Pressure	☐	☐	Shingles	☐	☐
Artificial Heart Valve	☐	☐	Excessive Bleeding	☐	☐	Hives or Rash	☐	☐	Sickle Cell Disease	☐	☐
Artificial Joint	☐	☐	Excessive Thirst	☐	☐	Hypoglycemia	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Fainting Spells/Dizziness	☐	☐	Irregular Heartbeat	☐	☐	Spina Bifida	☐	☐
Blood Disease	☐	☐	Frequent Cough	☐	☐	Joint Replacement	☐	☐	Stomach/Intestinal Disease	☐	☐
Blood Transfusion	☐	☐	Frequent Diarrhea	☐	☐	Kidney Problems	☐	☐	Stroke	☐	☐
Breathing Problems	☐	☐	Frequent Headaches	☐	☐	Leukemia	☐	☐	Swelling of Limbs	☐	☐
Bruise Easily	☐	☐	Frequently Tired	☐	☐	Liver Disease	☐	☐	Swollen Ankles	☐	☐
Cancer	☐	☐	Genital Herpes	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Chemotherapy	☐	☐	Glaucoma	☐	☐	Lung Disease	☐	☐	Tonsillitis	☐	☐
Chest Pains	☐	☐	Hay Fever/Allergies	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Cold Sores/Fever Blisters	☐	☐	Heart Attack/Failure	☐	☐	Pain in Jaw Joints	☐	☐	Tumors or Growths	☐	☐
Congenital Heart Disorder	☐	☐	Heart Murmur	☐	☐	Parathyroid Disease	☐	☐	Ulcers	☐	☐
Convulsions	☐	☐	Heart Pacemaker	☐	☐	Psychiatric Care	☐	☐	Venereal Disease	☐	☐
						Radiation Treatments	☐	☐	Yellow Jaundice	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
7. Do you have frequent headaches?	☐	☐
8. Do you clench or grind your teeth?	☐	☐
9. Do you bite your lips or cheeks frequently?	☐	☐
10. Have you ever had any difficult extractions in the past?	☐	☐
11. Have you ever had any prolonged bleeding following extractions?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials? If yes, date of placement _____	☐	☐
14. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
15. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments

Signature _____ Date _____