Dr. Panahpour
SYSTEMIC DENTIST

NAME: Last, First, Middle		☐ Male ☐ Female	TODAY'S DATE:
ADDRESS: Street or P.O. Box	City	State	Zip
PHONE NUMBERS: Home (circle preference)	Cellular		EMAIL
AGE:	BIRTH DATE:	☐ Single ☐ Married	SOCIAL SECURITY NO:
OCCUPATION:	EMPLOYER:		WORK PHONE NUMBER:
ADDRESS: Street or P.O. Box	City	State	Zip
SPOUSE OR PARENT:	BIRTH DATE:		SOCIAL SECURITY #:
OCCUPATION:	EMPLOYER:		PHONE NUMBER:
INSURED PERSON'S FULL NAME:	BIRTHDATE:		SOCIAL SECURITY #:
EMPLOYER'S NAME:	PHONE NUMBER:		INSURANCE COMPANY:
GROUP NAME:	GROUP NUMBER:		INSURANCE COMPANY NUMBER:
IN CASE OF EMERGENCY			ADDRESS:
PHONE NUMBERS: Home	Cellular		RELATIONSHIP TO PATIENT:

Whom may we thank for referring you? _____
Are any of your friends or family members patients of Dr. Pana?_____

Why did you select our practice? _____

For All Patients

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, the doctor and/or his staff will give a full explanation of the procedure(s) involved. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminder items sent via mail or email. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in the office.

_____

SIGNATURE OF RESPONSIBLE PARTY RELATIONSHIP DATE

PAYMENT OPTIONS

Dental treatment is an investment in an individual's medical and psychological wellbeing. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we are providing the following payment options.

Please review and download the payment option fee form for further information.

MEDICAL/DENTAL HISTORY

1) Do you presently have, or have had, pain or discomfort in the mouth, face, or jaws? ☐ YES ☐ NO
2) Do your gums bleed at any time? ☐ YES ☐ NO
3) Do you have aching or sensitive teeth? ☐ YES ☐ NO
4) Have you had an injury to your face or jaw? ☐ YES ☐ NO
5) Have you had serious trouble associated with any previous dental treatment? ☐ YES ☐ NO
6) Do you feel nervous or uneasy about having dental treatment? ☐ YES ☐ NO

7) Date of last dental treatment was _____

8) My main reason for coming today is

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9) Have you been a patient in a hospital during the past two years? ☐ YES ☐ NO
   If yes, for what reason? _____
10) Have you been under the care of a medical doctor during the past two years? ☐ YES ☐ NO
   If yes, for what reason? _____
11) Do you use tobacco products? ☐ YES ☐ NO
12) Do you drink alcoholic beverages? ☐ YES ☐ NO
   If yes, please list how many per week, e.g., 1-2 drinks/week: _____
13) Do you use recreational or street drugs?
14) Are you currently taking, or have you taken within the past two years, any prescription or non-prescription drugs? **If so, please list here:**

DRUG	DOSE/FREQUENCY	REASON FOR TAKING

15) Do you have any **allergies** (i.e., itching, rash, swelling of hands, eyes, or are you made sick by metals, jewelry, latex rubber, aspirin, penicillin, codeine, or any drugs, foods, medication? ☐ YES ☐ NO

If yes, allergic to what? _____

16) Have you ever had excessive bleeding requiring special treatment? ☐ YES ☐ NO
17) When you walk upstairs or take a walk, do you ever have to stop because of chest pain? ☐ YES ☐ NO
18) Do your ankles swell during the day? ☐ YES ☐ NO
19) Do you use more than two pillows to sleep? ☐ YES ☐ NO
20) Have you lost or gained more than 10 pounds in the last year? ☐ YES ☐ NO
21) Do you wake up short of breath? ☐ YES ☐ NO
22) Are you on a special diet? ☐ YES ☐ NO
23) Women: Are you pregnant now? ☐ YES ☐ NO
Are you currently using a prescription-type contraceptive? ☐ YES ☐ NO
24) Check any of the following which you have present or in the past:

- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Angina Pectoris (chest pain)
- ☐ Kidney Disease or Dialysis
- ☐ Stomach Problems or Ulcers
- ☐ Cancer
- ☐ Rheumatism
- ☐ Cortisone Medication
- ☐ Glaucoma
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Congenital Heart Lesions
- ☐ Scarlet Fever
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker

- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Artificial Joint
- ☐ Fat, Irregular Heartbeat
- ☐ Stroke
- ☐ Irritable Bowel
- ☐ Tumor
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Yellow Jaundice
- ☐ Hay Fever
- ☐ Allergies or Hives
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Radiation Treatment
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Sinus Trouble
- ☐ Pain in Jaw Joints
- ☐ AIDS or HIV antibody
- ☐ Blood Transfusion
- ☐ Drug Addiction
- ☐ Bruise Easily
- ☐ Sexually Transmitted Disease
- ☐ Cold Sores or Fever Blisters
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Sickle Cell Disease
- ☐ Hemophilia or Anemia
- ☐ Depression

26) Do you snore, clench, or grind your teeth?
☐ YES ☐ NO

27) Do you suffer from headaches or migraines?
☐ YES ☐ NO

28) Does your jaw click when you open your mouth?
☐ YES ☐ NO

29) Do you have difficulty opening your mouth completely?
☐ YES ☐ NO

30) Have you previously had orthodontic treatment?
☐ YES ☐ NO

31) Do you wear a retainer?
☐ YES ☐ NO

32) Do you medicate before dental treatment?
☐ YES ☐ NO

33) Do you have history of any genetic, congenital, or family-type disorder?
☐ YES ☐ NO

34) Do you have any disease, condition, or problem not listed?
☐ YES ☐ NO

If yes, please describe here:

_____

35) How do you feel about maintaining a healthy mouth?

_____

36) How do you feel about the appearance of your teeth?

_____

37) If you could change anything about your smile, what would you change?

_____

To the best of my knowledge, all of the preceding health and dental history answers are correct.

Signature: _____ Date: _____

Print: _____ Relationship to Patient