HEALTHY SMILE 360° | **Michael Mostofi, D.D.S.** | 15 Mareblu Ste 360 Aliso Viejo, CA 92656

DENTAL OFFICE NEW PATIENT FORM

Thank you for selecting our dental office.
To help us meet all of your health care needs, please complete this form as accurately as possible. ☺

I. PATIENT INFORMATION:

Today's Date:_____ E-mail Address:_____

Patient Full Name _____

Social Security # _____Birth Date __/___/____ Age ___

Male ( ) Female ( ) Marital Status _____

Address: _____

City: _____STATE:_____ ZIP: _____

Employer _____Occupation _____

Previous Dentist:_____ _____Phone:_____

Current Physician _____ Phone: _____

Whom may we thank for referring you? _____

II. TELEPHONE & EMAIL:

Home Phone _____ Work Phone _____

Cell Phone _____

Emergency Contact:

Name _____Relationship _____

Contact Phone _____ Work Phone _____

III. PERSON RESPONSIBLE FOR ACCOUNT:

Name _____

Relationship _____ Social Security # _____

Contact Phone _____ Date of Birth _____

IV. INSURANCE INFORMATION:

Primary Insurance:

Subscriber Name:_____ Date of Birth _____

Relationship to Patient:_____ Subscriber's SSN:_____

Insurance ID#:_____ Group ID#:_____

Insurance Name:_____

Insurance Telephone No.:_____

Secondary Insurance:

Subscriber Name:_____ Date of Birth _____

Relationship to Patient:_____ Subscriber's SSN:_____

Insurance ID#:_____ Group ID#:_____

Insurance Name:_____

Insurance Telephone No.:_____

V. NOTICES: Please Initial Below:

_____ I have read and understood the Dental Materials Fact Sheet

_____ I have read and understood HIPAA (Notice of Privacy Act)

_____ I assign Mostofi Dental Corporation all my right, title, and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by the assignee. I acknowledge that billing my insurance company for the services rendered is a courtesy done by MOSTOFI DENTAL CORPORATION. I am still responsible for paying the above- referenced dentist to the extent the relevant insurer or payer does not pay the dentist in full.

_____ I was notified: Payments are expected at the time services are rendered. That if I must change my appointment I must notify MOSTOFI DENTAL CORPORATION at least 48 hours notice to avoid a $55.00 fee. *(Emergencies are an exemption).

_____ I am aware that MOSTOFI DENTAL CORPORATION offers different payment plan options.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental series that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

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DENTAL HISTORY:

Reason for today's visit:_____

Your current dental health is: Good Fair Poor

Do you:

Require antibiotics before dental treatment? Y N

Have pain now? Y N

Now have or experienced pain /discomfort in your jaw joint ? Y N

Clench or grind your teeth while asleep or awake? Y N

Like your smile? Y N

Have bleeding gums? Y N

Have sensitivity in any of your teeth? Y N

You have family history of gum disease or tooth loss? Y N

Have mouth odors? Y N

Do food tend to be caught between your teeth? Y N

How many times a week do you floss?_____ a day do you brush? _____

Have you ever had:

Orthodontic treatment? Y N

Oral surgery? Y N

Periodontal treatment? Y N

Your teeth ground or the bite adjusted? Y N

A bite plate or mouth guard? Y N

Headaches, neck aches or shoulder aches? Y N

A serious/ difficult problem associated with any previous dental work? Y N

If so, please describe, including cause: _____

_____

A serious injury to the mouth or head? Y N

If so, please describe, including cause: _____

_____

Have you ever taken Phen-Fen? (also known as Redux or Pondimin) Y N

If so, when? _____

Have you ever taken Fosamax? Y N

If so, when? _____

Is there anything else you would like for Dr. Michael Mostofi to know?

_____

MEDICAL HISTORY:

Your current dental health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Y N

Are you currently under a physician's care? Y N

Please explain: _____

Are you taking any prescription/ over-the-counter drugs? Y N

Please list: _____

_____

For Women: Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: _____

Are you nursing? Y N

Have you ever had any of the following disease or medical problems?

(Please circle all options that apply)

Y N Anemia/Radiation Treatment	Y N Hemophilia/Abnormal Bleeding
Y N Artificial Bones/Joints/Valves	Y N Hepatitis
Y N Arthritis	Y N High/Low Blood Pressure
Y N Asthma	Y N HIV+/AIDS
Y N Blood Transfusion	Y N Hospitalized for Any Reason
Y N Cancer/Chemotherapy	Y N Kidney Problems
Y N Congenital Heart Defect	Y N Mitral Valve Prolapse
Y N Diabetes	Y N Psychiatric Problems
Y N Difficulty Breathing	Y N Severe/Frequent Headaches
Y N Drug/Alcohol Abuse	Y N Shingles
Y N Emphysema/Glaucoma	Y N Sickle Cell Disease/Traits
Y N Epilepsy/Seizures/Fainting Spells	Y N Sinus Problems
Y N Fever Blisters/Herpes	Y N Tuberculosis (TB)
Y N Heart Attack/Stroke	Y N Ulcers/Colitis
Y N Heart murmur	Y N Venereal Disease
Y N Heart Surgery/Pacemaker	Y N Thyroid

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine

Y N Jewelry/Metals Y N Tetracycline Y N Dental Anesthetics Y N Latex

Please list any other drugs/material that you are allergic to:

_____

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the patient named herein.

Initials:_____ Date:_____

Doctor's Comments:_____

Medical History Updates:

Date:_____ Comments:_____ Signature:_____