Inland Dental Group

John – Ohannes Tchaboukian D.D.S. ▌ 1131 Foothill Blvd La Verne, CA 91750

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. Thank you. ☺

I. PATIENT INFORMATION:

This appointment is for: ( ) Self ( ) Dependent

Patient Full Name _____ Social Security # _____

Birth Date _____ Age _____ Male ( ) F e m a l e ( ) Marital Status _____

Address _____ _____

Employer _____ Occupation _____

Previous Dentist _____Previous Dentist Phone _____

Current Physician _____Current Physician Phone _____

Whom may we thank for referring you? _____

II. TELEPHONE & EMAIL:

Home Phone _____ Work Phone _____ Cell Phone _____

Email: _____

In the event of an emergency, who should we contact: Name _____

Relationship _____ Contact Phone _____ Work Phone _____

III. RESPONSIBLE PARTY:

Name _____ Social Security # _____

Relationship _____ Contact Phone _____ Date of Birth _____

IV. INSURANCE INFORMATION:

Subscriber Name:_____ Relationship to Patient:_____ Date of Birth _____

Insurance ID#:_____ Subscriber's Social Security #:_____Group ID#:_____

Insurance Name:_____ Insurance Telephone No.:_____

V. NOTICES: Please Initial Below:

_____ I have received a copy Dental Materials Fact Sheet

_____ I have received a copy of HIPAA (Notice of Privacy Act)

_____I assign Inland Dental Group 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 Inland Dental Group. 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 Inland Dental Group at least 48 hours prior to avoid a $40.00 fee.
*(Emergencies are an exemption).

_____ I am aware that Inland Dental Group offers different payment plan options.

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DENTAL HISTORY

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____ Address _____

_____ Telephone _____

How often do you have dental examinations? _____ How often do you floss? _____

How often do you brush your teeth? _____

What other dental aids do you use? (Interplak, toothpicks, Floss, etc) _____

Do you have any dental problems now? YES N O
If yes, please describe:_____

Are any of your teeth sensitive to:

Hot or cold?	YES	NO
Sweets?	YES	NO
Biting or Chewing?	YES	NO

Have you noticed any mouth odors or bad tastes? YES NO

Do you frequently get cold sores, blisters or any other oral lesions?	YES	NO
Do your gums bleed or hurt?	YES	NO
Have your parents experienced gum disease or tooth loss?	YES	NO
Have you noticed any loose teeth or change in your bite?	YES	NO
Does food tend to become caught in between your teeth?	YES	NO

If yes, where: _____

DO YOU:

Clench or grind your teeth while awake or asleep?	YES	NO
Bite your lips or cheeks regularly?	YES	NO
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingerlnails)	YES	NO
Mouth breath while awake or asleep?	YES	NO
Have tired jaws, especially in the morning?	YES	NO
Smoke/chew tobacco?	YES	NO

HAVE YOU EVER HAD:

Orthodontic treatment?	YES	NO
Oral surgery?	YES	NO
Periodontal treatment?	YES	NO
Your teeth ground or the bite adjusted?	YES	NO
A bite plate or mouth guard?	YES	NO
A serious injury to the mouth or head?	YES	NO

If so, please describe, including cause _____

_____

HAVE YOU EVEREXPERIENCED:

Clicking or popping of the jaw?	YES	NO
Pain (joint, ear, side of face)?	YES	NO
Difficulty in chewing on either side of the mouth?	YES	NO
Headaches, neck aches or shoulder aches?	YES	NO
Sore muscles (neck, shoulders)?	YES	NO

Are you satisfied with your teeth's appearance? YES NO
Would you like to keep all of your teeth all of your life? YES NO

Do you feel nervous about having dental treatment)? YES NO
If so, what is your biggest concern:_ _____

Have you ever had an upsetting dental experience? YES NO
If yes, please describe _____

_____

_____

Is there anything else about having dental treatment you would like for us to know?

_____

_____

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CONFIDENTIAL HEALTH HISTORY

Patient Name:_____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER: (Leave blank if you do not understand the question)

YES/NO Is your general health good? If NO, explain: _____

YES/NO Has there been a change in your health within the last year? If YES, explain: _____

YES/NO Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain: _____

YES/NO Are you being treated by a physician now? If YES, explain: _____

Date of last medical exam? _____ Reason for exam: _____

YES/NO Have you had problems with prior dental treatment? If YES, explain: _____

Date of last dental exam?_ _____ Name of Last treating dentist: _____

YES/NO Are you in pain now? If YES, explain: _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (Please circle Yes or No for each)

YES/NO	Chest pain (angina)	YES/NO	Blood in stools	YES/NO	Frequent vomiting
YES/NO	Fainting spells	YES/NO	Diarrhea or constipation	YES/NO	Jaundice
YES/NO	Recent significant weight loss	YES/NO	Frequent urination	YES/NO	Dry mouth
YES/NO	Fever	YES/NO	Difficulty urinating	YES/NO	Excessive thirst
YES/NO	Night Sweats	YES/NO	Ringing in ears	YES/NO	Difficulty swallowing
YES/NO	Persistent cough	YES/NO	Headaches	YES/NO	Swollen ankles
YES/NO	Coughing up blood	YES/NO	Dizziness	YES/NO	Joint pain or stiffness
YES/NO	Bleeding problems	YES/NO	Blurred vision	YES/NO	Shortness of breath
YES/NO	Blood in urine	YES/NO	Bruise easily	YES/NO	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

YES/NO	Heart disease	YES/NO	AIDS/HIV	YES/NO	Psychiatric care
YES/NO	Family history of heart disease	YES/NO	Surgeries	YES/NO	Osteoporosis
YES/NO	Heart attack	YES/NO	Hospitalization	YES/NO	Thyroid disease
YES/NO	Artificial joint	YES/NO	Diabetes	YES/NO	Asthma
YES/NO	Stomach problems or ulcers	YES/NO	Family history of diabetes	YES/NO	Hepatitis
YES/NO	Heart defects	YES/NO	Tumors or cancer	YES/NO	Sexual transmitted disease
YES/NO	Heart murmurs	YES/NO	Chemotherapy	YES/NO	Herpes
YES/NO	Rheumatic fever	YES/NO	Radiation	YES/NO	Canker or cold sores
YES/NO	Skin disease	YES/NO	Arthritis, rheumatism	YES/NO	Anemia
YES/NO	Hardening of arteries	YES/NO	Emphysema or other lung disease	YES/NO	Liver disease
YES/NO	High blood pressure	YES/NO	Kidney or bladder disease	YES/NO	Eye disease
YES/NO	Seizures	YES/NO	Stroke	YES/NO	Transplants
YES/NO	Cosmetic surgery	YES/NO	Eating disorders	YES/NO	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REATION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

YES/NO	Aspirin	YES/NO	Valium	YES/NO	Metal
YES/NO	Darvon	YES/NO	Demerol	YES/NO	Tetracycline
YES/NO	Codeine	YES/NO	Penicillin	YES/NO	Vicodin
YES/NO	Latex	YES/NO	Food	YES/NO	Percodan
YES/NO	Local anesthetic (Lidocaine or Septocaine)	YES/NO	Erythromycin	YES/NO	Nitrous oxide
YES/NO	Other_____				

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V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

YES/NO	Recreational drugs	YES/NO	Tobacco in any form	YES/NO	Antibiotics
YES/NO	Over-the-counter medicines	YES/NO	Alcohol	YES/NO	Supplements
YES/NO	Weight loss medications	YES/NO	Bisphosphonate (Fosamax) Oral / IV	YES/NO	Aspirin

Please list: _____

VI. WOMEN ONLY (Please circle Yes or No for each)

YES/NO Are you or could you be pregnant? If YES, what month? _____

YES/NO Are you nursing?

YES/NO Are you taking birth control pills?

VII. ALL PATIENTS (Please circle Yes or No for each)

YES/NO Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: _____

YES/NO Have you ever been pre-medicated for dental treatment?

If YES, why? _____

Have you ever taken Phen-Phen? YES/NO If YES, when: _____

VIII. <u>Is there any issue or condition that you would like to discuss with the dentist in private?</u> YES/NO

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name & Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____	_____
Signature of Patient (Parent/Guardian)	**Date**	**Signature of Dentist**	**Date**