PARADISE DENTAL

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Welcome to Paradise Dental.

We are committed to excellence in dental care and are proud of our dedication to our patients.

Section 1: PATIENT INFORMATION:

Today's Date: Month: [ ] Day: [ ] Year: [ ]

Patient Name:	Birth Date: M: [ ] D: [ ] Y: [ ]	Age:	Gender: Male [ ] Female [ ]
Social Security Number:	**Driver's License Info:** Number: State:		**Occupation:**
Maritial Status Info: Single: [ ] Maried: [ ] Divorced: [ ] Seperated: [ ] Widowed: [ ]	**Employer Name:**		
Previous Dentist:	**Dentist Phone #:**	**Previous Physician:**	**Physician Phone #:**
Whome we may thank for referring you:	**Friend/Relative Name:**	**Insurance Company:**	**Web Site:**
Direct Mail: [ ] Waliking By: [ ] Yahoo: [ ] Bing: [ ] Facebook: [ ] Other Internet: [ ] Magazine Name:			

Section 2: EMAIL, TELEPHONE AND ADDRESS INFORMATION

Email Address:	Home Phone: ( )	Work Phone: ( )	Mobile Phone: ( )
Address:	**City:**	**State:**	**Zip:**

Section 3: EMERGENCY CONTACT INFORMATION

Person Name:	Relationship:	Phone #: Work #: Mobile #:

Section 4: SPOUSE'S INFORMATION

Full Name:	Birth Date: M: [ ] D: [ ] Y: [ ]		Spouse Social Security Number:
Occupation:	**Employer:**		**Phone #:** Work #: Mobile #:

Section 5: PERSON RESPONSIBLE FOR ACCOUNT (IF DIFFERENT FROM PATIENT)

Full Name:	Birth Date: M: [ ] D: [ ] Y: [ ]		Social Security Number:
Relationship:	**Phone #:** Work #: Mobile #:		**Employer:**

Section 6: PRIMARY INSURANCE INFORMATION

Insurance Name:	Subscriber Name:	Relationship to Patient:
Insurance ID Number:	**Group ID Number:**	**Insurance Telephone Number:**

Section 7: SECONDARY INSURANCE INFORMATION

Insurance Name:	Subscriber Name:	Relationship to Patient:
Insurance ID Number:	**Group ID Number:**	**Insurance Telephone Number:**

Section 8: NOTICES (PLEASE INITIAL BELOW ON EACH ROW)

[_____] I have read and understood the Dental Materials Fact Sheet.

[_____] I have read and understood HIPPA (Notice Of Privacy Act).

[_____] I will answer all health questions to the best of my knowledge

[_____] There may be a charge for any missed appointments not cancelled 24 hours before the appointment time.

Section 9: I CONSENT

After explanation by doctor, I hereby authorize the performance of dental services upon the above name patients and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature:	Date:	Relationship to Patient:

Section 10: AGREEMENT TO PAY

I agree to pay for all services rendered at the time of the service. In the event that payment is not made with thirty (30) days of receipt of statement, a service charge at the legal rate may be added to the passed due balance. If a collection agency services are required, I further agree to pay for all legal fees and costs incurred in connection therewith. Service charges not paid when due shall be added to arid become part of principal and bear like interest until paid. I also understand that in order to collect my debt, my credit history may be checked through the use of my social security number or any other information I have given you. I understand that any and all fees incurred for dental treatment are my total and ultimate responsibility, regardless of any insurance I may have. In the event that my insurance does not provide benefits or provides a reduced benefit, I will be financially responsible to pay up to the agreed upon fee schedule.

Signature:	Date:

Dr. Mojgan Niktash, D.D.S. 31726 Ranch Viejo Road, San Juan Capistrano, CA 92675

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. Niktash 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:_____