DANNY SHIRI, D.D.S.

Cosmetic and Implant Dentistry

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PATIENT INTRODUCTION & HEALTH HISTORY

DATE _____

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program. In order to do this we must know as much about you as we do about your teeth. ALL INFORMATION, OF COURSE, WILL BE HELD IN STRICT CONFIDENCE.

PATIENT

Name_____ Email_____

If child: Parent's Name_____ Cell Phone_____

Date of Birth_____ Age_____ Home Phone_____

Address_____ City_____ Zip Code_____

Employed by_____ Position_____ Business Phone_____

Business Address_____ City_____ Zip Code_____

S/S # _____ D/L # _____

SPOUSE

Name_____

Employed by_____ Position_____ Business Phone_____

Business Address_____ City_____Zip Code_____

Convenient Appointment Time_____

Are you available for appointments on short notice?_____

Is another member of your family, or relative a patient at our office?_____

In case of emergency, who should be notified?_____ Phone_____

DENTAL INSURANCE

Name of Insured _____ Employer_____

I.D. or S/S # of Insured _____ Birthdate_____ Relationship_____

Insured Co._____ Group/Plan No._____ Effective Date_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

DO YOU HAVE, OR DID YOU EVER HAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES/NO

- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ High blood pressure
- ☐ ☐ Heart disease from childhood
- ☐ ☐ Heart murmur
- ☐ ☐ Rheumatic fever
- ☐ ☐ Use of Phen-Fen
- ☐ ☐ Pacemaker
- ☐ ☐ Vascular graft
- ☐ ☐ Heart valve replacement
- ☐ ☐ Heart attack
- ☐ ☐ Heart surgery
- ☐ ☐ Congestive heart failure
- ☐ ☐ Angina (chest pain)
- ☐ ☐ Irregular heart beat
- ☐ ☐ Stroke
- ☐ ☐ Increased cholesterol

Respiratory:

YES/NO

- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Tuberculosis
- ☐ ☐ Other_____

Endocrine/Hematologic/ oncologic/Immune:

YES/NO

- ☐ ☐ Diabetes
- ☐ ☐ Thyroid disease
- ☐ ☐ Hemophilia
- ☐ ☐ Sickle cell disease
- ☐ ☐ Bleeding tendency
- ☐ ☐ Anemia
- ☐ ☐ Cancer
- ☐ ☐ Radiation therapy
- ☐ ☐ Chemotherapy
- ☐ ☐ HIV infection/AIDS
- ☐ ☐ Organ transplant
- ☐ ☐ Blood transfusion

GI/GU:

YES/NO

- ☐ ☐ Hepatitis (A,B,C, or other?)
- ☐ ☐ Kidney dialysis
- ☐ ☐ Ulcers
- ☐ ☐ Sexually transmitted disease
- ☐ ☐ Denied permission to give blood

Musculo-Skeletal/CNS/ Development:

YES/NO

- ☐ ☐ Joint replacement
- ☐ ☐ Osteoarthritis
- ☐ ☐ Rheumatoid arthritis
- ☐ ☐ Spinal cord injury
- ☐ ☐ Seizures
- ☐ ☐ Cerebral palsy
- ☐ ☐ Mental retardation
- ☐ ☐ Dementia

Psychological:

YES/NO

- ☐ ☐ Anxiety/Nervousness
- ☐ ☐ Depression
- ☐ ☐ Mental health treatment
- ☐ ☐ Eating disorder

Social:

YES/NO

- ☐ ☐ Do you use tobacco products?
- ☐ ☐ Do you drink alcohol?
- ☐ ☐ Every day? If so, how much?_____
- ☐ ☐ Do you use recreational drugs?

1. Are you allergic to: ___Penicillin ___Codeine ___Novocaine ___Aspirin ___Sulfa ___Latex ___Other_____
2. Presently taking medication?_____Please list:_____
3. Date of last physical exam_____
4. Are you now under the care of a physician?_____if so for what condition_____
5. Name of physician_____Phone_____
6. Do you smoke?_____
7. Have you had any serious illness or operation_____if so what_____
8. Any other disease or condition not listed_____
9. Woman Are you pregnant?_____Are you breast feeding now?_____ Are you taking birth control pills?_____
10. Have you ever been premedicated with antibiotics for dental treatment?_____

DENTAL HISTORY

What concerns you most?_____
Are you having discomfort at this time?_____What is the discomfort?_____
How long since you have been to a dentist?_____What was done then?_____
Did you have X-Rays?_____How often did you visit a dentist before then?_____
Have you lost any teeth?_____ Any complications with extractions?_____
Are your teeth sensitive to: heat_____ cold_____ sweets_____ sour_____
Have you ever had your teeth straightened?_____ When?_____
How often do you brush your teeth ?_____ Do you use dental floss?_____
Do you have bleeding gums?_____ Where?_____
Have you ever had gum treatment?_____ When?_____
Does food wedge between your teeth?_____ Where?_____
Do you grind or clench your teeth?_____ When?_____
Do you have any pain around your ear?_____ Do you hear popping or clicking noises when you chew?_____
Any swelling or lump in your mouth?_____
Do you have any fear of having dentistry done?_____
How do you feel about the appearance of your teeth?_____

To the best of my knowledge all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I am directly and fully responsible for payment submitted by doctor for services rendered. If this account is assigned for collection and/or suit, collection cost and interest and/or Attorney fee and court costs will be added to the amount due. Any returned check will incur bank fees.
I hereby authorize Dr. Danny Shiri to perform any and all treatment for myself or child (if patient is a minor). I also consent to such methods, X-rays, drugs, and agents as may be indicated in the connection with treatment. This consent will remain in effect until cancelled.

Signature of Patient or Guardian _____ Date _____