Name:_____ **Marital Status:** ◯**Single** ◯**Married** ◯**Divorced** ◯**Other** ◯**Child**
Last, First Middle Initial

Phone:_____ **E-mail:** _____**Occupation:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Emergency Contact:_____ **Relationship:** _____ **Phone:**_____

Dental History

Check If You Have Problems with any of the Following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping of jaw
- ☐ Jaw pain
- ☐ Food collection between teeth
- ☐ Grinding or clinching teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal Disease
- ☐ Sensitivity to hot or cold
- ☐ Sore or growths in mouth

*Is there anything you would like to improve regarding your oral health and/or smile? ◯Yes ◯ No
If so, please explain:_____

*Would you be interested in discussing Botox or Fillers for cosmetic or TMJ treatment with the doctor? ◯ Yes ◯ No

Medical History

Physician's Name_____ Date of Last Visit_____

*Have you had any joint replacements (ex: hip/knee) ◯Yes◯No *Have you been instructed/required to pre-medicate prior to a dental procedure? ◯Yes ◯ No If yes,Reason why and date:_____
*Have you ever had any major surgeries and/or blood transfusion? ◯Yes ◯No If yes, date:_____
*Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯No
*Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Check if you have allergies to any of the following:

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Metal(s)
- ☐ Latex
- ☐ Sulfa Drugs

Other: _____

WOMEN: Pregnant: ◯ Yes ◯ No Nursing? ◯Yes ◯ No Taking oral Contraceptives? ◯Yes ◯ No

Check if you have or have had any of the following:

- ☐ AIDS
- ☐ Alzheimer's Disease
- ☐ Artificial Heart Valves
- ☐ Autism
- ☐ Blood disease
- ☐ Cancer
- ☐ Cough up Blood
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/ Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Epilepsy Fainting
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease/ Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Issues
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tumors/Growths

Medications (Including aspirin regimens and vitamins): _____

Authorization & Financial Policy:
I authorize my insurance company to pay Laleh Sarfaraz, D.D.S.,P.C., all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and the dentist, to release all information necessary to secure the payment of benefits. I understand the insurance estimates given are according to information provided by my insurance company and are in no way a guarantee that services will be covered. Laleh Sarfaraz, D.D.S.,P.C. is happy to bill insurance companies for our patients, and accept assignments of benefits, but ultimately the entire bill remains the patient's responsibility. It is up to the patient to resolve any conflicts with their insurance company. All payments are due at the time of service. If a patient fails to make a payment at the time of service, full payment will be required prior to all future appointments. We reserve the right to charge a broken appointment fee of $25 per half hour for all appointments not cancelled during business hours at least 48 hours prior to the appointment time. Upon the practice's discretion, all future appointments may be cancelled if a patient does not contact the office after a missed appointment. In the event a patient's account is placed in the hands of an attorney, or collection agency, the patient's account will be charged a collection fee that is 33.5% of their total account balance. I have read and agree to the above Authorization & Financial Policy:

Signature: _____Date: _____Relationship to patient:_____