GLENDALE DENTAL ARTS

Office of Vic Halajian, D.D.S.,Inc & Associates

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ MI _____ *MALE* ☐ *FEMALE* ☐

ADDRESS _____ # _____ CITY _____ ST _____ ZIP _____

DATE OF BIRTH _____ *SINGLE* ☐ *MARRIED* ☐ *DIVORCED* ☐ *SEPARATED* ☐ *WIDOWED* ☐

MINORS: MOTHER'S NAME _____ HER DOB _____ FATHER'S NAME _____ HIS DOB _____

PATIENT'S SS# _____ DL# _____ ST _____ **HOME** ☎ ( ) _____

INSURANCE SUBSCRIBER _____ SS# OR INS. ID# _____ **CELL** ☎ ( ) _____

EMPLOYED BY _____ POSITION _____ **WORK** ☎ ( ) _____

WORK ADDRESS _____ CITY _____ ST _____ ZIP _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **EMERGENCY** ☎ ( ) _____

NAME OF ANOTHER RELATIVE NOT LIVING WITH YOU _____ **RELATIVE** ☎ ( ) _____

SPOUSE'S NAME _____ **SPOUSE'S CELL** ☎ ( ) _____

SPOUSE'S EMPLOYER _____ POSITION _____ **SPOUSE'S WORK** ☎ ( ) _____

SPOUSE'S WORK ADDRESS _____ CITY _____ ST _____ ZIP _____

SPOUSE'S SS# _____ DL# _____ ST _____ SPOUSE'S DOB _____

DENTAL INFORMATION

	YES	*NO*
ARE YOU HAVING PAIN OR DISCOMFORT?	☐	☐
DO YOU THINK YOU HAVE CAVITIES?	☐	☐
DO YOU THINK YOU HAVE GUM DISEASE?	☐	☐
DO YOUR GUMS EVER BLEED?	☐	☐
DO YOU HAVE LOOSE TEETH?	☐	☐
DOES FOOD CATCH BETWEEN YOUR TEETH?	☐	☐
DO YOU WANT TO KEEP YOUR REMAINING TEETH?	☐	☐
DO YOUR JAW JOINTS HURT, CLICK OR POP?	☐	☐
DO YOU GRIND OR CLENCH YOUR TEETH?	☐	☐
DO YOU HAVE CHIPPED OR BROKEN TEETH?	☐	☐

	YES	*NO*
DO YOU BRUSH AT LEAST ONCE A DAY?	☐	☐
DO YOU FLOSS AT LEAST ONCE A DAY?	☐	☐
DO YOU SMOKE OR USE TOBACCO?	☐	☐
DO YOU DRINK MUCH ALCOHOL?	☐	☐
ARE YOU INTERESTED IN COSMETIC DENTISTRY?	☐	☐
ARE YOU INTERESTED IN BLEACHING?	☐	☐
ARE YOUR TEETH SENSITIVE TO COLD?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEETS?	☐	☐
WERE YOU HAPPY WITH YOUR PREVIOUS DENTIST?	☐	☐

WHY? _____

WHEN WAS YOUR LAST DENTAL VISIT? _____ WHEN WAS YOUR LAST X-RAY EXAM? _____

WHAT WAS DONE AT THAT TIME? _____ WHEN WAS YOUR LAST CLEANING? _____

MEDICAL INFORMATION

	YES	*NO*	*PLEASE EXPLAIN OR LIST IF APPLICABLE*
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW?	☐	☐	_____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	☐	☐	_____
ARE YOU TAKING ANY MEDICATIONS OR DRUGS NOW?	☐	☐	_____
HAVE YOU TAKEN ANY MEDICATION OR DRUG IN THE PAST 5 YEARS?	☐	☐	_____
ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS OR LATEX?	☐	☐	_____
SENSITIVE OR ALLERGIC TO ANY FOODS OR HOUSEHOLD MATERIALS?	☐	☐	_____

PHYSICIAN'S NAME _____ **PHYSICIAN'S** ☎ ( ) _____

PHYSICIAN'S ADDRESS _____

FOR WOMEN ONLY

	YES	*NO*	*MAYBE*	*MONTH*
ARE YOU PREGNANT?	☐	☐	☐	_____
ARE YOU NURSING / BREAST-FEEDING?	☐	☐		
ARE YOU TAKING BIRTH-CONTROL PILLS?	☐	☐		

WARNING: THE EFFECTIVENESS OF BIRTH-CONTROL PILLS IS REDUCED BY ANTIBIOTICS. IF YOU ARE PRESCRIBED ANTIBIOTICS, USE OTHER FORMS OF BIRTH-CONTROL DURING THIS CYCLE AND NEXT TO AVOID PREGNANCY.

CONTINUED ON BACK ➜

MEDICAL HISTORY

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? IF YES, PLEASE SUPPLY THE DATE OF OCCURRENCE.

	DATE	YES	NO		DATE	YES	NO		DATE	YES	NO
ORGAN TRANSPLANT		☐	☐	ARTIFICIAL JOINTS (Hip, knee, etc.)		☐	☐	EPILEPSY OR SEIZURES		☐	☐
ANY HEART CONDITION		☐	☐	KIDNEY TROUBLE		☐	☐	FAINTING OR DIZZY SPELLS		☐	☐
HEART ATTACK		☐	☐	ULCERS		☐	☐	HEPATITIS A (Infectious)		☐	☐
HEART MURMUR		☐	☐	DIABETES .. TYPE 1 ☐ ... 2 ☐		☐	☐	HEPATITIS B (Serum)		☐	☐
MITRAL VALVE PROLAPSE		☐	☐	THYROID PROBLEMS		☐	☐	HEPATITIS ____ (List other)		☐	☐
ARTIFICIAL HEART VALVE		☐	☐	GLAUCOMA		☐	☐	LIVER DISEASE		☐	☐
ANGINA (CHEST PAIN)		☐	☐	CANCER		☐	☐	YELLOW JAUNDICE		☐	☐
CONGENITAL HEART DISEASE		☐	☐	RADIATION THERAPY		☐	☐	BRUISE EASILY		☐	☐
IRREGULAR HEART BEAT		☐	☐	CHEMOTHERAPY		☐	☐	HEMOPHILIA		☐	☐
PACEMAKER		☐	☐	TUMORS OR GROWTHS		☐	☐	ANEMIA		☐	☐
HEART SURGERY		☐	☐	ASTHMA		☐	☐	BLOOD TRANSFUSION		☐	☐
ARTERIOSCLEROSIS		☐	☐	EMPHYSEMA		☐	☐	HIV POSITIVE		☐	☐
SHORTNESS OF BREATH		☐	☐	TUBERCULOSIS OR COUGH		☐	☐	AIDS		☐	☐
SCARLET FEVER		☐	☐	HAY FEVER		☐	☐	SICKLE CELL DISEASE		☐	☐
RHEUMATIC FEVER		☐	☐	SINUS PROBLEMS		☐	☐	GENITAL HERPES		☐	☐
HIGH BLOOD PRESSURE		☐	☐	ARTHRITIS		☐	☐	VENEREAL DISEASE		☐	☐
LOW BLOOD PRESSURE		☐	☐	RHEUMATISM		☐	☐	COLD SORES OR FEVER BLISTERS		☐	☐
STROKE		☐	☐	DEVELOPMENTAL DISABILITY		☐	☐	OSTEOPOROSIS		☐	☐
NERVOUSNESS		☐	☐	CORTISONE MEDICATION		☐	☐	OSTEOPOROSIS MEDICATIONS		☐	☐

OTHER CONDITION NOT LISTED: _____

DO YOU EVER HAVE SHORTNESS OF BREATH OR CHEST PAIN WHEN YOU WALK UP STAIRS? _____

HAVE YOU USED BISPHOSPHONATE MEDICATIONS (*EXAMPLES*: FOSAMAX, BONIVA, AREDIA, ZOMETA, ACTONEL)? _____

REFERRAL INFORMATION

PLEASE TELL US HOW YOU CHOSE OUR OFFICE: TV ☐ INTERNET ☐ FRIEND ☐ INSURANCE ☐ OTHER: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

CONSENT

To the best of my knowledge, all the preceding answers are correct. If any changes occur in my health status or medication regimen, I shall inform the office staff immediately verbally and in writing. I authorize this office to obtain pertinent medical information from my physician as it relates to my dental health. Additionally, I authorize this office to obtain information on my behalf from my insurance company to determine eligibility and benefits for dental services. I authorize this office to bill my insurance company and receive payment directly. However, I understand that insurance coverage is not guaranteed. If for any reason my insurance company does not cover or pay this office for any charges incurred, I accept full responsibility and will pay my bill immediately.

✎ _____ I understand that I, the patient (parent / legal guardian), am fully responsible for all charges incurred in this office.
Initials

✎ _____ I understand that all records and x-rays are the legal property of this office and there is a fee for duplication.
Initials

✎ _____ I have read and agree to the OFFICE POLICIES (*v. May 19, 2009*) reviewed in the office or on the web site.
Initials

✎ _____ I have read and agree to the HIPAA PRIVACY RULES (*v. Mar. 5, 2009*) reviewed in the office or on the web site.
Initials

✎ _____ I have received the NOTICE OF PRIVACY PRACTICES (*v. Feb. 19, 2008*) in the office or on the web site.
Initials

✎ _____ I have received the DENTAL MATERIALS FACT SHEET in the office or on the web site.
Initials

With my signature below I agree to all of the above and authorize any dentist in this office to perform a dental examination. I am aware of the risks, benefits, and alternatives to x-rays and agree to have x-ray images taken as needed.

X _____ DATE _____
Signature (parent or guardian if patient is a minor)

REVIEWED BY DR. _____ DATE _____

UPDATED

DR. _____ DATE _____
DR. _____ DATE _____
DR. _____ DATE _____
DR. _____ DATE _____

v. Aug. 11, 2009, GDA