GLENDALE DENTAL ARTS

Office of John Gazarian, 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 ID# ______ E-MAIL ADDRESS ______ **CELL** ☎ ( ) ______

EMPLOYED BY ______ POSITION ______ **BUS.** ☎ ( ) ______

BUS. 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 ______ DOB ______ **SPOUSE'S CELL** ☎ ( ) ______

SPOUSE'S EMPLOYER ______ POSITION ______ **SPOUSE'S BUS.** ☎ ( ) ______

SPOUSE'S BUS. 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?	☐	☐
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? ______

WHAT WAS DONE AT THAT TIME? ______

WHEN WAS YOUR LAST X-RAY EXAM? ______

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 ➔