



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 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		YES	NO
ARE YOU HAVING PAIN OR DISCOMFORT?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU BRUSH AT LEAST ONCE A DAY?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU THINK YOU HAVE CAVITIES?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU FLOSS AT LEAST ONCE A DAY?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU THINK YOU HAVE GUM DISEASE?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU SMOKE OR USE TOBACCO?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOUR GUMS EVER BLEED?	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU DRINK MUCH ALCOHOL?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE LOOSE TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU INTERESTED IN COSMETIC DENTISTRY?	<input type="checkbox"/>	<input type="checkbox"/>
DOES FOOD CATCH BETWEEN YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU INTERESTED IN BLEACHING?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU WANT TO KEEP YOUR REMAINING TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOUR TEETH SENSITIVE TO COLD?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOUR JAW JOINTS HURT, CLICK OR POP?	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOUR TEETH SENSITIVE TO SWEETS?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU GRIND OR CLENCH YOUR TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	WERE YOU HAPPY WITH YOUR PREVIOUS DENTIST?	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE CHIPPED OR BROKEN TEETH?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	_____
HAVE YOU EVER BEEN HOSPITALIZED OR HAD A MAJOR OPERATION?	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARE YOU TAKING ANY MEDICATIONS OR DRUGS NOW?	<input type="checkbox"/>	<input type="checkbox"/>	_____
HAVE YOU TAKEN ANY MEDICATION OR DRUG IN THE PAST 5 YEARS?	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATIONS OR LATEX?	<input type="checkbox"/>	<input type="checkbox"/>	_____
SENSITIVE OR ALLERGIC TO ANY FOODS OR HOUSEHOLD MATERIALS?	<input type="checkbox"/>	<input type="checkbox"/>	_____
PHYSICIAN'S NAME _____			PHYSICIAN'S ☎ () _____
PHYSICIAN'S ADDRESS _____			

FOR WOMEN ONLY

	YES	NO	MAYBE	MONTH
ARE YOU PREGNANT?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARE YOU NURSING / BREAST-FEEDING?.....	<input type="checkbox"/>	<input type="checkbox"/>		
ARE YOU TAKING BIRTH-CONTROL PILLS?.....	<input type="checkbox"/>	<input type="checkbox"/>		

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.