EST · 2004
ARLINGTON
DENTAL CENTER

Family & Cosmetic Dentistry
Peajmun Razmjou DDS PLLC

Patient Information

Name ______________________ ______________________ __________
Last Name / First Name / Middle Initial

Address ______________________ ______________ ______ ________
Street Address / City / State / Zipcode

Gender ☐ male ☐ female **Status** ☐ single ☐ married ☐ divorced

Date of Birth ________/_______/_________ **Age** _______ **E-Mail** ______________________

Social Security Number ___________ - _________ - ______________

Home Phone (_______) _______ - _________ **Work Phone** (_______) _______ - _________ **Cell** (_______) _______ - _________

Emergency Contact ______________________ ______________________ **Telephone** (_______) _______ - _________
Last Name / First Name

▶How did you hear about our office? ☐ Insurance Company/Website ☐ Phone Book ☐ Advertisement ☐ Referral by family member or friend

▶ If referred by family member or friend please provide his/her name: ______________________

▶ Fill out this section if the patient is a minor or has a legal guardian

Legal Guardian ______________________ **Relationship to patient** ______________________

Insurance Information

Insurance Company Name ______________________ **Group Number** ______________ **Policy/ID Number** ______________

Address ______________________ ______________ ______ ________
Street Address / City / State / Zipcode

Name of Employer ______________________ **Telephone** (_______) _______ - _________

▶ Fill out this section if the insurance coverage for the patient is provided by another family member

Name of Insured ______________________ ______________________ **Relationship to patient** ______________
Last Name / First Name

Social Security Number _______ - _______ - __________ **DOB:** ____/____/_____ **Is he/she currently a patient in our practice?** ☐ yes ☐ no

Patient Medical History

1. Are you under medical treatment now? ☐ yes ☐ no
2. Have you been hospitalized in the past 5 years for any serious illness or surgical operation? ☐ yes ☐ no
3. Do you use tobacco? ☐ yes ☐ no
4. Do you use any controlled substance(s)? ☐ yes ☐ no
5. Are you wearing contact lenses? ☐ yes ☐ no

6. If you are currently taking any medications, please list: ______________________
7. If you are allergic to any of the following, please specify:

☐ Penicillin or any other Antibiotics
☐ Barbiturates
☐ Sulfa Drugs
☐ Sedatives
☐ Local Anesthetics
☐ Latex Rubber

8. Do you have or have you had any of the following?

☐ High Blood Pressure
☐ Heart Attack
☐ Rheumatic Fever
☐ Swollen Ankles
☐ Fainting / Seizures
☐ Asthma
☐ Low Blood Pressure
☐ Epilepsy / Convulsions
☐ Leukemia

☐ Diabetes
☐ Kidney Diseases
☐ Heart Murmur
☐ Thyroid Problem
☐ Heart Disease
☐ Cardiac Pacemaker
☐ Angina
☐ Anemia
☐ Emphysema

☐ Radiation Therapy
☐ Glaucoma
☐ Recent Weight Loss
☐ Liver Disease
☐ Heart Trouble
☐ Respiratory Problems
☐ Mitral Valve Prolapse
☐ AIDS or HIV Infection

☐ Other ______________________

9. Women Only:
a. Are you Pregnant or think you may be pregnant? ☐ yes ☐ no
b. Are you nursing? ☐ yes ☐ no
c. Are you taking oral contraceptives? ☐ yes ☐ no

Please Turn the page

COPYRIGHT 2004-2017 - All Rights Reserved - Arlington Dental Center

ARLINGTON DENTAL CENTER
EST · 2004

Family & Cosmetic Dentistry
Peajmun Razmjou DDS PLLC

Patient Dental History

1. Which of the following services you are interested in? (checkmark all that applies)

☐ Regular cleaning & check-up ☐ Cosmetic dentistry ☐ Bleaching ☐ Orthodontics (Braces)
☐ Reconstructive work (crown & bridges) ☐ Implants ☐ Sedation dentistry ☐ Consultation

2. Do you like your smile? ☐ yes ☐ no

3. How often do you brush? ☐ More than once a day ☐ Once a day ☐ few times a week ☐ Do not brush

4. How often do you floss? ☐ More than once a day ☐ Once a day ☐ few times a week ☐ Do not floss

5. Are your teeth sensitive to hot or cold liquids / foods? ☐ yes ☐ no
6. Are your teeth sensitive to sweet or sour liquids / foods? ☐ yes ☐ no
7. Do you feel pain to any of your teeth? ☐ yes ☐ no
8. Do you have any sores or lumps in or near your mouth? ☐ yes ☐ no
9. Do your gums bleed while brushing or flossing? ☐ yes ☐ no
10.Do you clench or grind your teeth? ☐ yes ☐ no
11. Do you have frequent headaches? ☐ yes ☐ no
12. Have you had any orthodontic treatment? ☐ yes ☐ no
13. Do you have problem opening or closing your jaw? ☐ yes ☐ no
14. Do you bite your lips or cheeks frequently? ☐ yes ☐ no
15. Have you ever had any difficult extractions in the past? ☐ yes ☐ no
16. Have you ever had any prolonged bleeding following extractions? ☐ yes ☐ no
17. Do you wear dentures or partials? ☐ yes ☐ no

Assignment and Authorization

I hereby consent to an x-ray, laboratory procedures, anesthesia, dental or surgical treatments rendered which Arlington Dental Center may consider or advise in the treatment of my case and guarantee payments of the charges incurred. I hereby assign and authorize payment of insurance benefits directly to Peajmun Razmjou DDS PLLC, T/A Arlington Dental Center, and hereby authorize this dental practice to release information requested on this form. I understand that payment is due at the time service is rendered, and Arlington Dental Center will submit my insurance claims on my behalf. I understand that If there is a balance left in my account and has not been paid by the due date, Arlington Dental Center may elect to turn the account for collection. Should collection become necessary, the responsible party agrees to pay all additional collection and legal fees, including attorney fees and court cost. In addition, I understand that a minimum of 24-hour notice is required to cancel my scheduled appointment(s). I hereby authorize Arlington Dental Center to charge my account $50 per missed appointment. Arlington Dental Center reserves the right to inactive any patient that cancels two or more appointments.

Signature: ____ **Date:** _______ / _______ /________

Acknowledgement of Receipt of Notice of Privacy Practices

***you may refuse to sign this acknowledgement**

I ____ have received a copy of this office's Notice of Privacy Practices.
Please print name

Signature: ____ **Date:** _______ / _______ /________

▶ Office Use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtain because:

☐ Individual refused to sign
☐ Communication barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowlegement

☐ Other (Please specify) ____

COPYRIGHT 2004-2017 - All Rights Reserved - Arlington Dental Center