Rockville Family Dentistry

Patient Information (Confidential)
Date_____

Name_____ __ Birthdate_____ Home Phone_____

Address_____ City_____ State_____ Zip Code_____

Email_____ Cell Phone_____

Employer/School_____ Phone_____

Whom may we thank for referring you _____

Person to contact in case of emergency_____

Responsible Party

Name_____ Relationship to patient_____

Address_____ City_____ State_____ Zip_____

Phone_____

Insurance Information

Name of insured_____ Birthdate_____ SS#_____

Name of Employer_____ Insurance Company_____

Address_____ City_____ State_____ Zip_____

Phone_____ Group#_____ Policy #_____

Relationship to patient_____

Secondary Insurance Information

Name of insured_____ Birthdate_____ SS#_____

Name of Employer_____ Insurance Company_____

Address_____ City_____ State_____ Zip_____

Phone_____ Group #_____ Policy #_____

Patient Medical History

Physician_____ Office Phone_____ Date of last exam_____
Are you under medical treatment now? Yes____ No____
Have you been hospitalized for any surgical operation or serious illness? Yes_____ No_____
Are you taking any medications? Yes _____No_____ if yes, what medications are you taking_____
Have you ever taken Fen-Phen /Redux? Yes_____ No_____
Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates Yes_____ No_____ Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hour?Yes_____
Do you use tobacco? Yes____ No_____ Controlled Substances Yes_____ No_____

Are you allergic to or have had any reactions to the following

Local Anesthetics (e.g. novocaine) Yes_____ No_____
Penicillin or any other antibiotic Yes_____ No_____
Sulfa drugs Yes_____ No_____ Barbiturates Yes_____ No_____ Sedatives Yes_____ No_____
Iodine Yes_____ No_____ Aspirin Yes_____ No_____ Any Metals Yes_____ No_____
Latex Rubber Yes_____ No_____ Other (please list) _____

Women Only

Are you pregnant or think you may be pregnant Yes_____ No_____
Are you nursing Yes_____ No _____
Are you taking oral contraceptives Yes_____ No _____

Medical History

High Blood Pressure? Yes ___No____ Heart Attack/ Heart Disease? Yes__ No__ Chest Pains? Yes___ No___
Rheumatic fever? Yes___ No ___ Fainting / Seizures? Yes____ No___ Asthma? Yes___ No___
Low Blood pressure? Yes___ No___ Epilepsy? Yes___ No___ Leukemia? Yes____ No____
Diabetes? Yes____ No____ Kidney Disease? Yes____ No____ Thyroid Problems? Yes____ No ____
Aids/HIV/Sexually Transmitted Disease? Yes_____ No_____ Pacemaker? Yes_____ No_____
Heart Murmur? Yes____ No____ Angina? Yes___ No ____ Anemia? Yes_____ No_____
Emphysema? Yes____ No____ Cancer? Yes_____ No_____ Arthritis? Yes_____ No_____
Joint Replacement (knee or hip)? Yes_____ No_____ Date of replacement_____
Stroke/ Yes_____ No_____ Tuberculosis? Yes_____ No_____ Glaucoma/ Yes_____ No_____
Radiation Therapy or Chemotherapy? Yes_____ No_____ Date received_____
Liver Disease? Yes ___No___ Respiratory problems? Yes___ No___ Mitral Valve Prolapse? Yes___ No___
Any Transplants? Yes___ No_____ If yes when was it done_____
Other not listed_____

Dental History

Name of previous dentist_____ Phone_____ last exam_____
Do your gums bleed while brushing or flossing? Yes_____ No_____
Are your teeth sensitive to hot or cold liquids/foods? Yes_____ No_____
Do you feel pain in any of your teeth? Yes_____ No_____
Do you have any sores or lumps in or near your mouth? Yes_____ No_____
Have you ever had any head, neck or jaw injuries? Yes___ No___ If yes, when_____
Have you ever experienced any of the following problems in your jaw?
Clicking? Yes____ No_____ Pain? Yes ___ No___ Difficulty opening, closing or chewing? Yes____No___
Do you have frequent headaches? Yes___ No___ Clench or grind your teeth? Yes___ No____
Do you bite your cheeks or lips frequently? Yes___ No___
Have you had Orthodontic treatment? Yes___ No_____ If yes when_____
Do you wear partials or dentures? Yes___ No____ If yes, Date of placement_____
Do you like your smile? Yes_____ No_____ If no, why ?_____
What can our office do to help you achieve the smile you've always wanted? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health and dental treatment. I authorize Dr. Modarres to release any information, including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Shahram Modarres, insurance benefits otherwise payable to me. I understand for any reason my insurance does not pay for services rendered, that, I, the patient/guardian am solely responsible for the balance due.

Print Patients Name_____ Date_____
Signature of patient/Parent/Guardian_____Date_____