

Name _____ Address _____
 City _____ State _____ Zipcode _____ Home Phone _____ Work Phone _____
 Date of Birth _____ Sex _____ Height _____ Weight _____ Occupation _____
 Soc Sec # _____ Single _____ Married _____ Name of Spouse _____
 Closest Relative _____ Phone _____

Eligible Member Information

Employee Soc Sec # _____ Employee Name _____ Group # _____
 Where Employed _____ Employer Address _____

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.

- | | | |
|--------------------------|--------------------------|--|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Are you in good health? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has there been any change in your general health within the past year? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. My last physical exam was on _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Are you now under the care of a physician?
If so, what is the condition being treated? _____ Name of Physician _____
Physician's Address _____ Phone Number _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you had any serious illness or operation?
If so, what was the illness or operation? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you been hospitalized or had a serious illness within the past five (5) years?
If so, what was the problem? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have or have you had any of the following diseases or problems? |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Damaged heart valves or artificial heart valves, including heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Congenital heart lesions |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have pain in your chest upon exertion? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you ever short of breath after mild exercise? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do your ankles swell? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a cardiac pacemaker? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Allergy
If so, what are you allergic to? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Sinus trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Asthma or hay fever |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Hives or a skin rash |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Fainting spells or seizures |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you have to urinate more than six times a day? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you thirsty much of the time? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Does your mouth frequently become dry? |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Hepatitis, jaundice, or liver disease |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Inflammatory rheumatism (painful swollen joints) |
| <input type="checkbox"/> | <input type="checkbox"/> | m. Stomach ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | n. Kidney trouble |
| <input type="checkbox"/> | <input type="checkbox"/> | o. Tuberculosis |
| <input type="checkbox"/> | <input type="checkbox"/> | p. Do you have a persistent cough or cough up blood? |
| <input type="checkbox"/> | <input type="checkbox"/> | q. Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | r. Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | s. Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | t. Psychiatric problems |
| <input type="checkbox"/> | <input type="checkbox"/> | u. Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | v. AIDS or other immunosuppressive disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | w. Other: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Do you bruise easily? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Have you ever required a blood transfusion?
If so, explain the circumstances _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you have any blood disorder such as anemia? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck? |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Are you taking any drug or medicine?
If so, what? _____ |

(Continued on other side)

PATIENT NAME: _____

PREVIOUS MEDICAL HISTORY

YES NO

- 12. Are you taking any of the following:
 - a. Antibiotics or sulfa drugs
 - b. Anticoagulants (blood thinners)
 - c. Medicine for high blood pressure
 - d. Cortisone (steroids)
 - e. Tranquilizers
 - f. Antihistamines
 - g. Aspirin
 - h. Insulin, tolbutamide (Orinase), or similar drug
 - i. Digitalis or drugs for heart trouble
 - j. Nitroglycerin
 - k. Oral contraceptives or other hormonal therapy
 - l. Other

- 13. Are you allergic or have you reacted adversely to:
 - a. Local anesthetics
 - b. Penicillin or other antibiotics
 - c. Sulfa drugs
 - d. Barbiturates, sedatives, or sleeping pills
 - e. Aspirin
 - f. Iodine
 - g. Codeine or other narcotics
 - h. Other _____

14. What is your chief dental complaint: _____

- 15. Have you had any serious trouble associated with any previous dental treatment?
 If so, explain _____
- 16. Do you have any disease, condition, or problem not listed above that you think I should know about?
 If so, explain _____
- 17. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation?
- 18. Are you wearing removable dental appliances?

WOMEN

- 19. Are you pregnant?
- 20. Do you have any problems associated with your menstrual period?
- 21. Are you nursing?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

 Signature of Patient Date

 Signature of Dentist Date

General Consent

I hereby authorize **FARROKH ERFAN, D.D.S.** to employ such treatments and technical procedures as may be deemed necessary or advisable in the dental treatment of _____

I understand that this authorization will cover all aspects of routine dental care including administration of x-rays, photographic records, local anesthetics, sedative drugs, and treatments including preventive and restorative dentistry (cleaning and scaling of teeth, fillings, root canal treatments, orthodontic care, and the fitting of dentures, crowns, and bridges), and minor surgical procedures (extractions and gum surgery).

I understand that this authorization shall remain in full effect for the present visit as well as for subsequent visits during the course of treatment. All of my questions have been answered.

Signature of Patient: _____ Date: _____
 (If a minor, parent or guardian must sign)

Witness: _____