Just for Your Smile

Sam Osseiran, D.D.S., M.S., M.A.G.D.

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your oral health.

1. PATIENT INFORMATION

Date: _____ Email: _____

Patient Name: _____ Occupation: _____

SS #: _____ Patient Employer: _____

Address: _____ School/School Phone #: _____

City: _____ Whom may we thank for referring you?

State: _____ Zip: _____ Direct Mail ◯ Zocdoc ◯ Yelp ◯ Family/Friends ◯

Gender: M____ F____ D.O.B.: _____ Insurance ◯ Google ◯ Other: _____

Marital Status: (Circle one that applies to you)

Married Separated Widowed Divorced Single Partnered Minor

Responsible Party - IF SAME AS ABOVE PLEASE SKIP

Full Name: _____ Cell #: _____ Work #: _____

Address: _____ Relationship to Patient: _____

City: _____ SS #: _____

State: _____ Zip: _____ D.O.B.: _____

2. PHONE NUMBERS

Cell #: _____ Home #: _____ Work #: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____ Phone #: _____

3. DENTAL INSURANCE

Primary: MEDICAL ◯ DENTAL ◯ (Check One) Secondary: MEDICAL ◯ DENTAL ◯ (Check One)

Insured's Name: _____ Insured's Name: _____

SS/ID #: _____ D.O.B.: _____ SS/ID #: _____ D.O.B.: _____

Employer: _____ Employer: _____

Group #: _____ Group #: _____

Plan Name: _____ Plan Name: _____

Address: _____ Address: _____

City: _____ City: _____

State: _____ Zip: _____ State: _____ Zip: _____

Insurance Phone #: _____ Insurance Phone #: _____

4. DENTAL HISTORY

Reason For Visit: _____

Former Dentist: _____

City / State / Zip: _____

Date of Last Dental Visit: _____

Date of Last Dental X-Ray: _____

How Often Do You Floss? _____

How Often Do You Brush? _____

Please check YES or NO to indicate if you have had any of the following:

Bad Breath	◯ Yes	◯ No	Jaw Pain or Tiredness	◯ Yes	◯ No
Bleeding Gums	◯ Yes	◯ No	Loose Teeth or Broken Fillings	◯ Yes	◯ No
Blisters on Lips or Mouth	◯ Yes	◯ No	Mouth Breathing	◯ Yes	◯ No
Burning Sensation on Tongue	◯ Yes	◯ No	Mouth Pain	◯ Yes	◯ No
Cigarette, Pipe, or Cigar Smoking	◯ Yes	◯ No	Orthodontic Treatment	◯ Yes	◯ No
Clicking or Popping Jaw	◯ Yes	◯ No	Periodontal Treatment	◯ Yes	◯ No
Dry Mouth	◯ Yes	◯ No	Sensitivity to Temperature	◯ Yes	◯ No
Food Collection Between Teeth	◯ Yes	◯ No	Sensitivity to Sweets	◯ Yes	◯ No
Grinding Teeth	◯ Yes	◯ No	Sensitivity when Chewing	◯ Yes	◯ No
Gums Swollen or Tender	◯ Yes	◯ No	Sores or Growths in Mouth	◯ Yes	◯ No

5. MEDICAL HISTORY

Physician's Name: _____ Date of Last Visit: _____

Physician Phone #:_____ Pharmacy: _____ Phone #: _____

Please check YES or NO to indicate if you have had any of the following:

AIDS	◯ Yes	◯ No	Headaches	◯ Yes	◯ No	Shortness of Breath	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Heart Problems	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Arthritis, Rheumatism	◯ Yes	◯ No	Hepatitis Type ____	◯ Yes	◯ No	Skin Rash	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Special Diet/Weight Loss	◯ Yes	◯ No
Back Problems	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	HIV Positive	◯ Yes	◯ No	Swollen Feet or Ankles	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	Jaundice	◯ Yes	◯ No	Swollen Neck Glands	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Jaw Pain	◯ Yes	◯ No	Thyroid Problems	◯ Yes	◯ No
Circulatory Problems	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	Tonsilitis	◯ Yes	◯ No
Cortisone Treatments	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cough, Persistent or Blood	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No	Tumor or Growths	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Nervous Problems	◯ Yes	◯ No	Ulcer	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No	Radiation Treatment	◯ Yes	◯ No			
Fainting or Dizziness	◯ Yes	◯ No	Respiratory Disease	◯ Yes	◯ No			
Glaucoma	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No			

Have you ever had any complications following dental treatment? ◯ Yes ◯ No

If yes, please describe_____

_____

Have you ever been hospitalized or do you have any other health concerns? ◯ Yes ◯ No

If yes, please describe_____

_____

Women: Are you pregnant? ◯ Yes ◯ No

Due Date: _____

Are you nursing? ◯ Yes ◯ No

Taking birth control pills? ◯ Yes ◯ No

Have you ever taken any of these medications?

Blood Thinners	◯ Yes	◯ No
Coumadin	◯ Yes	◯ No
Warafin	◯ Yes	◯ No
Diet Medications	◯ Yes	◯ No
Dextenfluramine	◯ Yes	◯ No
Fen-Phen	◯ Yes	◯ No
Pondimin	◯ Yes	◯ No
Redux	◯ Yes	◯ No

Have you ever used bisphosphonate medication?

Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ◯ Yes ◯ No

Have you ever had or been diagnosed with:

Artificial Heart Valves	◯ Yes	◯ No
Artificial Joints, Screws, Pins	◯ Yes	◯ No
Abnormal Bleeding with Surgery	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No
Congenital Heart Lesions	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No
Hernia Repair	◯ Yes	◯ No
Mitral Valve Prolapse	◯ Yes	◯ No
Pacemaker	◯ Yes	◯ No
Rheumatic Fever	◯ Yes	◯ No

Are you allergic to:

Aspirin	◯ Yes	◯ No
Barbiturates	◯ Yes	◯ No
Codeine	◯ Yes	◯ No
Ibuprofen	◯ Yes	◯ No
Latex	◯ Yes	◯ No
Local Anesthesia	◯ Yes	◯ No
Metals (i.e. nickel)	◯ Yes	◯ No
Penicillin	◯ Yes	◯ No

Other:_____

Please PRINT all medications now taking:_____

Patient Signature: _____ **Date:** _____