GET ACQUAINTED QUESTIONNAIRE

Name ____ Today's Date_______________

Age _________________ Date of Birth _____________________ Telephone (   ) ______________________

Fax (   )______________ E-Mail ____________________ Cell (   ) _______________ Pager (   ) _________

Address ________________________________ City ___________________ State ____ Zip ___________

How long? __________ Own?____ Rent?_____ Previous Address _______________________________

Driver's License No. ___________________________ Social Security No. _________________________

Whom may we thank for referring you? ____

What is the purpose of this visit? ____

If a student, school attended ____________________________________ Full Time? _______________

Employer _______________________________ Occupation ____________________ How Long? ______

Address ____ Telephone (   ) ________________

Spouse's Name ____ Date of Birth _________________

Employer _______________________________ Occupation ____________________ How Long? ______

Address ____ Telephone (   ) ________________

Driver's License No. _________________________________ Social Security _______________________

In case of emergency, please provide us with the name and address of closest relative or friend not living with you.

____

His/Her Telephones: Home (   ) __________________________ Business (   ) _________________________

Who is financially responsible for this bill? ________________ Social Security ______________________

DENTAL INSURANCE INFORMATION

Name of Insurance Carrier for You: ______________________________ Spouse ______________________

Name of Group Dental Plan _________________________________ Group Number _________________

If you have dental insurance, we will help you to determine the approximate coverage you have available. We ask that you assign your insurance benefits to us, unless you pay full in advance. Professional care is provided to you, our patient, and not to an insurance company. Thus, the insurance company is responsible to you, the patient and you, the patient are responsible to compensate the doctor. We will help in every way we can in filling your claim and/or handling insurance questions on your behalf.

Accounts outstanding more than 30 days from treatment date will bear interest at 1.5% per month or 18% per year. Patient agrees to pay reasonable attorney or collection agency fees and court costs in the event that collection effort or legal action is required to enforce payment.

In order to satisfy an outstanding balance, the following credit card may be used:

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Account No. ____ Expiration Date: __________________

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

I authorize Dr. Kalantari and Team to release x-rays and treatment information to other treating dentist and insurance companies. I release Dr. Kalantari and Team from any liability related to disclosure of confidential or privileged information.

____

Patient's Signature or Parent's Signature *Today's Date*

THANK YOU FOR YOUR COOPERATION

For Office Use Only

Special precautions: HB:

HEALTH QUESTIONNAIRE

Name____ **Birth Date**____________________

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle yes or no, whichever applies, in response to the following questions. Your answers are for records only and will be considered confidential.

DENTAL

1. Reason for today's visit: ☐ Dental Emergency ☐ Initial Consultation ☐ Check-up ☐ Cleaning ☐ Other____________________
   ☐ Chief Complaint ____

2. Date of last dental visit____________ What treatment was performed____________________Date of last X-ray____________
3. Date of last dental cleaning____________Name of previous Dentist____________________Telephone #____________________

4. Do you use ☐ electronic ☐ manual toothbrush Fluoride Rinse ☐ yes ☐ no Dental Floss ☐ yes ☐ no Other____________________

5. Have you received Oral Hygiene instructions regarding the care of your teeth and gums ☐ yes ☐ no

6. Check (√) if you have had problems with any of the following:

   ☐ Bad Breath ☐ Broken Teeth ☐ Grinding, clenching teeth ☐ Bleeding gums ☐ Clicking or popping jaw

   ☐ Food collection between teeth ☐ Difficulty opening or closing jaw ☐ Loose Teeth

   ☐ Sores or Growth in your mouth ☐ Shifting of teeth ☐ Loose or poor fitted dental prosthesis

   ☐ Sensitivity to ☐ Hot ☐ Cold ☐ Sweets ☐ When biting down ☐ Dark, discolored teeth

7. Do you wear Dentures or Partials ☐ Yes ☐ No
8. Have you ever had orthodontic treatment ☐ Yes ☐ No

9. Have you ever had dental implants ☐ Yes ☐ No
10. Do you require Antibiotics before dental treatment ☐ Yes ☐ No

11. Have you ever been treated for periodontal disease (Gum disease, pyorrhea) ☐ Yes ☐ No If so, when____________________

12. Have you ever had any problems or complications with previous dental treatments ☐ Yes ☐ No
    If so, please explain____

13. Have you had any unpleasant dental experience or is there anything about dentistry that you strongly dislike ☐ Yes ☐ No

14. Do you like your smile ☐ Yes ☐ No
15. Would you like your teeth whiter ☐ Yes ☐ No

16. Are there any cosmetic changes you would like to have done to your teeth ☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge and have correctly answered. I understand that incorrect information can be dangerous to my health. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.
I hereby give my consent for the performance of a complete oral-facial examination including but not limited to x-rays and photographs.

________________________________ ________________________________

Signature of Patient **Date** **Signature of Dentist** **Date**

Doctor's Comments: ____

____

____

Signature ________________________________ **Date** ____________________

Please Turn Page→

HEALTH HISTORY

I. CIRCLE THE APPROPRIATE ANSWER: (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? ____________________
4. Yes No Are you now under the care of a physician? Date of last medical exam? ____________________
5. Physician's name____________________ 6. Telephone number____________________

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina) 18. Yes No Dizziness
8. Yes No Swollen ankles
9. Yes No Shortness of breath
10. Yes No Recent weight loss, fever, night sweats
11. Yes No Persistent cough, coughing up blood
12. Yes No Bleeding problems, bruising easily
13. Yes No Sinus problems
14. Yes No Difficulty swallowing
15. Yes No Diarrhea, constipation, blood in stools
16. Yes No Frequent vomiting, nausea
17. Yes No Difficulty urinating, blood in urine
19. Yes No Ringing in ears
20. Yes No Headaches
21. Yes No Fainting spells
22. Yes No Blurred vision
23. Yes No Seizures
24. Yes No Excessive thirst
25. Yes No Frequent urination
26. Yes No Dry mouth
27. Yes No Jaundice
28. Yes No Joint pain, stiffness

III. DO YOU OR HAVE YOU HAD:

29. Yes No Heart disease
30. Yes No Heart attack, heart defects
31. Yes No Heart murmurs
32. Yes No Rheumatic fever
33. Yes No Stroke, hardening of arteries
34. Yes No High Blood Pressure
35. Yes No Asthma, TB, emphysema, other lung diseases
36. Yes No Hepatitis, other liver disease
37. Yes No Stomach problems, ulcers
38. Yes No Allergies to: drugs, foods, medications, latex
39. Yes No Family history of diabetes, heart problems, tumors
40. Yes No AIDS, HIV +
41. Yes No Tumors, cancer
42. Yes No Arthritis, rheumatism
43. Yes No Eye diseases
44. Yes No Skin diseases
45. Yes No Anemia
46. Yes No VD, (syphilis, gonorrhea)
47. Yes No Herpes
48. Yes No Kidney, bladder disease
49. Yes No Thyroid, adrenal disease
50. Yes No Diabetes

IV. DO YOU OR HAVE YOU HAD:

51. Yes No Psychiatric care
52. Yes No Radiation treatment
53. Yes No Chemotherapy
54. Yes No Prosthetic heart valve
55. Yes No Artificial joint
56. Yes No Hospitalization
57. Yes No Blood transfusions
58. Yes No Surgeries
59. Yes No Pacemaker
60. Yes No Contact lenses

V. ARE YOU TAKING

61. Yes No Antibiotics/Sulfa drugs
    Yes No Blood thinners
    Yes No Blood Pressure medication
    Yes No Thyroid medication
    Yes No Cortisone/steroids
    Yes No Antihistamines/Allergy drugs
    Yes No Tranquilizers
    Yes No Insulin, other diabetes drugs
    Yes No Recreational drugs
    Yes No Digitalis, other heart medications
    Yes No Nitroglycerine
    Yes No Aspirin
    Yes No Other medications____________
62. Yes No Tobacco in any form; alcohol
63. Yes No Are you or could you be pregnant or nursing
64. Yes No Are you taking hormone medication
65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: ____________________ Date: ____________________

Doctor's signature: ____________________ **Date:** ____________________

Informed Consent

I authorize Dr. Kalantari, associates and staff to perform dental services for __________________, as verbally agreed upon, and/or as indicated on the treatment plan in the chart, as long as ___________, am/is a patient in the office. I understand the recommended treatment, associated fees, and required time.

These dental services may include surgery deemed necessary or advisable as a corollary to the planned treatment. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition or different from those now contemplated, I further request and authorize the doctor to do whatever he/she deems advisable.

I have been informed and understand that occasionally there are complications of the treatment * drugs and anesthesia including plain * infection * swelling * bleeding * discoloration * numbness and tingling of the lip, tongue, chin, gum, cheeks and teeth * pain and numbness * and thrombophlebitis (inflammation to a vein) from intravenous and intramuscular injection * injury to and stiffening of neck and facial muscles * change in occlusion or temporomandibular joint difficulty * injury to adjacent teeth or restorations in other teeth * injury to other tissues * referred pain to ear, neck and head * nausea * vomiting * allergic reactions * bone fractures * bruises * delayed healing * sinus complications and nasal antral fistulas and openings * sore lips, cheeks * speech alteration.

Tooth sensitivity to hot or cold may persist for several weeks, months, or, in rare instances, permanently; gum recession (shrinkage); temporary, or, in rare instances, permanent interference with phonetics (speech sounds); clicking, pain and disfunction in temporomandibular joints (jaw joints); tooth mobility (looseness); varying degree of spaces between teeth resulting in food becoming caught between the teeth after eating; and unesthetic exposure of crown (cap) margins may result from dental and/or periodontal therapy.

I further understand that if no treatment is rendered, my present dental and/or periodontal condition will probably worsen in time, which may result in premature tooth loss.

Every effort upon the part of the doctor and staff will be made to attain a successful result, however no guarantee or warranty can be given to me that the proposed treatment will be successful to my complete satisfaction. A risk of failure, relapse, or worsening of my present condition is unlikely, yet may occur. I understand that long-term success also requires my continue cooperation with daily prevention (home plaque control and nutrition) and periodic maintenance visits for an indefinite period of time.

I consent to photographs (Kodachromes) of my oral and facial structures and their publication for educational and scientific purposes.

I certify that I have read fully and understand the above consent to the operation, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

__________________   ____________________________________
Date   Print name of Patient or Legal Guardian

__________________   ____________________________________
Signature of Doctor   Signature of Patient or Legal Guardian