Anait Alabyan D.D.S.
General, Cosmetic and Implant Dentistry

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REGISTRATION AND HEALTH HISTORY

Name of Patient _____ Date of Birth _____

Street Address _____ Apt _____ City _____ State _____ Zip _____

Home Phone (____) _____ Cell Phone (____) _____ Email _____

Patient Employed by _____ City _____ Work Phone ( ) _____ EXT____

Occupation _____ Social Security Number _____ Drivers License Number _____

Name of Spouse _____ Phone (____) _____

Emergency Contact _____ Relationship _____ Phone ( ) _____ EXT____

Person Responsible for this Account _____ Relation to Patient _____ Dental Insurance? ☐ Yes ☐ No

Who May We Thank for Referring You to Our Office? _____

MEDICAL HISTORY

Family Physician's Name _____ City _____ Phone ( ) _____

Please mark (x) your response to indicate if you have or have not had any of the following diseases or problems.

	Y	N		Y	N		Y	N		Y	N
Heart Disease or Attack			Allergy to Penicillin			Epilepsy			Radiation Theraphy (Cancer)		
Angina Pectoris			Allergy to Local Anesthetic			Fainting or Dizzy Spell			Chemotheraphy (Cancer)		
High Blood Pressure			Allergy to any Medicine			Anemia			Venereal Diseas		
Heart Murmur			Allergy to Latex			Kidney Trouble			Psychiatric Care		
Mitral Valve Prolapse			Glaucoma			Ulcers			AIDS or HIV Positive		
Rheumatic Fever			Emphysema			Artificial Joints (Hip, Knee)			Asthma		
Artificial Heart Valve			Tuberculosis (TB)			Diabetes			Sinus Trouble		
Heart Pacemaker			Hepatitis A or B			Thyroid Disease			Allergies or Hives		
Heart Surgery			Liver Disease			Cortisone Medicine			Arthritis		
Stroke			Hemophillia (Bleeding)			Frequent Cold Sores			Drug Addiction		

Are you In Good health? ☐ Yes ☐ No

Do you have any disease, problem, or condition not listed? ☐ Yes ☐ No If Yes, what? _____

Have you been under the care of a Physician during the last 2 years? ☐ Yes ☐ No

Are you currently under care of a Physician? ☐ Yes ☐ No If Yes, for What Reason? _____

Are you now taking any medication drugs, or pills? ☐ Yes ☐ No If Yes, Please list _____

Have you ever taken any weight loss pills? ☐ Yes ☐ No If Yes, Please list _____

Are you pregnant? ☐ Yes ☐ No Are you taking Birth Control Pills? ☐ Yes ☐ No

Are you taking or scheduled to begin taking either of the medications,
aledronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's diseas? ☐ Yes ☐ No

Allergy to: _____

ABOVE INFORMATION IS TRUE: To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my physician to be contacted for details and advice.

Patient (or Guardian) Signature _____ Date_____

MEDICAL HISTORY REVIEW: I have reviewed this medical history and have added any changes since my last review.

Initial_____Date_____	Initial_____Date_____	Initial_____Date_____	Initial_____Date_____	Initial_____Date_____	Initial_____Date_____

DENTAL HISTORY

What prompted you to seek dental care at this time? _____

_____

How Long since you have been to a dentist? _____

Are you satisfied with your past dental care? ☐ Yes ☐ No

Has the fear of discomfort kept you from regular dental visits?

☐ Yes ☐ No

Have you lost any teeth? ☐ Yes ☐ No

Why? _____

Have they been replaced by: ☐ Fixed Bridge ☐ Removal Partial

☐ Implant ☐ Denture

Are you happy with the replacement? ☐ Yes ☐ No

Would you like to know more about pemanent replacements?

(IMPLANTS) ☐ Yes ☐ No

Are your teeth sensitive to: ☐ Heat ☐ Cold ☐ Bitting Pressure

Have you had your teeth straightened (braces)? ☐ Yes ☐ No

Do you have discolored, chipped, or crooked teeth that esthetically bother you? ☐ Yes ☐ No

How often do you brush your teeth? _____ Floss? _____

Do you smoke, how much? _____

Do your gums bleed when you brush or floss? ☐ Yes ☐ No

Does food get caught between any of your teeth? ☐ Yes ☐ No

Have you ever been told you have periodontal (gum) disease?

☐ Yes ☐ No

Have you ever had periodontal (gum) treatments? ☐ Yes ☐ No

Are you aware of any swelling or lump in your mouth? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you jaw muscles ever feel stiff, tired, or painful? ☐ Yes ☐ No

Are you aware of your jaw clicking, popping, or making grating-like noises? ☐ Yes ☐ No

Have you ever had TMJ treatments? ☐ Yes ☐ No

Have you ever worn a nightguard or bite splint? ☐ Yes ☐ No

CONSENT: The undersigned hereby authorized the Doctor to take X-rays, study models, photograps, or any other diagnostic alds deemed appropriate by Doctor to make a throrough diagnosis of the patient's dental needs. I also authorize Doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $2 rebilling fee, whichever is greater, may be added to my account. In the case of default or payment I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this acount.

Patient (or Guardian) Signature _____ Date _____

IF YOU HAVE DENTAL INSURANCE... Please complete the following thoroughly. We can place the information into our computer and bill you Insurance carrier automatically. This service is FREE to you. A completed and signed insurance form MUST be provided on each visit unless otherwise informed by this office. As an additional courtesy, our office will accept assignment of benefits if you sign the release below.

PRIMARY INSURANCE

Insured's Name _____ Birthdate _____

Social Sec. # _____ Employeed ID # _____

Insurance Company _____

City _____ State ____

Employer _____

City _____ How Long with Company? ____

SECONDARY INSURANCE

Insured's Name _____ Birthdate _____

Social Sec. # _____ Employeed ID # _____

Insurance Company _____

City _____ State ____

Employer _____

City _____ How Long with Company? ____

ASSIGNMENT INSURANCE BENEFITS: I hereby authorize and request my Insurance Company to pay directly to the Doctor the amount due on my claim for services rendered to me or my depentent. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference.

SIGNED _____ Date _____

FOR COMPLETION BY DENTIST

Comments: _____