



Ahmad Soolari, DMD, PC
NEW PATIENT REGISTRATION FORM

(Please Print)

Today's Date:					PID:					
PATIENT INFORMATION										
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs.		Marital status:	
									Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Birthdate	Sex:	Age:	Social Security no.:		Street address:			City, State:		ZIP Code:
	M F									
Home phone:		Business phone:		Cell phone:	Occupation:	Employer:		Patient's Email:		
Do you have insurance? If so, insurance name:				Primary policy holder, if not self:		Policy holder's Birthdate:		Relationship:		
<input type="checkbox"/> Y <input type="checkbox"/> N										
Doctor who referred you:				Who can we contact in case of emergency?			Phone no.:		Relationship:	
DENTAL INFORMATION										
(Please answer the following questions.)										
Do your gums bleed when you brush?			<input type="checkbox"/> Y <input type="checkbox"/> N		How would you describe your current dental problem?					
Have you ever had orthodontic (braces) treatment?			<input type="checkbox"/> Y <input type="checkbox"/> N							
Are your teeth sensitive to cold, hot, sweets or pressure?			<input type="checkbox"/> Y <input type="checkbox"/> N		Date of your last dental exam:					
Do you have earaches or neck pains?			<input type="checkbox"/> Y <input type="checkbox"/> N		Date of last dental x-rays:					
Have you had any periodontal (gum) treatments?			<input type="checkbox"/> Y <input type="checkbox"/> N		What was done at that time?					
Do you wear removable dental appliances?			<input type="checkbox"/> Y <input type="checkbox"/> N		How do you feel about the appearance of your teeth?					
Have you had a serious/difficult problem associated with any previous dental treatment? If yes, please explain:			<input type="checkbox"/> Y <input type="checkbox"/> N		Do you feel very nervous about going to the dentist?					
					Have you ever had a bad experience at the dentist?					
MEDICAL INFORMATION										
<i>If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.</i> Have you had any of the following diseases or problems? 1. Active tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N 2. Persistent cough greater than 3 week duration <input type="checkbox"/> Y <input type="checkbox"/> N 3. Cough that produces blood <input type="checkbox"/> Y <input type="checkbox"/> N					Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness or problem? <input type="checkbox"/> Y <input type="checkbox"/> N					
					Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking? <input type="checkbox"/> Y <input type="checkbox"/> N					
Are you in good health? <input type="checkbox"/> Y <input type="checkbox"/> N					Prescribed: _____ Over the counter: _____					
Has there been any change in your general health within the past year? <input type="checkbox"/> Y <input type="checkbox"/> N					Vitamins, natural or herbal preparations and/ore diet supplements: _____					
					Do you use drugs or other substance for recreational purposes? <input type="checkbox"/> Y <input type="checkbox"/> N					
Are you now under the care of a physician? If yes, what is/are the condition(s) being treated? <input type="checkbox"/> Y <input type="checkbox"/> N					Frequency of use: (daily, weekly, etc) _____					
					Number of years of recreational drug use? _____					
Date of last physical examination: _____					Are you alcohol or drug dependent? <input type="checkbox"/> Y <input type="checkbox"/> N					
Primary Physician: _____					If yes, have you received treatment? _____					
Address: _____					Do you drink alcoholic beverages? <input type="checkbox"/> Y <input type="checkbox"/> N					
Phone: _____					If so how much in the past 24 hours? _____ Past week? _____					
Woman Only:					Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenflurramine) or phen-fen (fenfluramine-phentermine combination)? <input type="checkbox"/> Y <input type="checkbox"/> N					
Are you or could you be pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N					Do you use tobacco (smoking, snuff, chew)? <input type="checkbox"/> Y <input type="checkbox"/> N					
Nursing? <input type="checkbox"/> Y <input type="checkbox"/> N					If yes, how interested are you in stopping? (circle one)					
Taking birth control pills/ hormonal replacement? <input type="checkbox"/> Y <input type="checkbox"/> N					-very -somewhat - not interested					

Please (X) a response to indicate if you have or have not had any of the following diseases or problems:	Y	N	D K	Continued...	Y	N	DK	Are you allergic or have you had a reaction to? (check) <input type="radio"/> None <input type="radio"/> Local anesthetics <input type="radio"/> Aspirin <input type="radio"/> Penicillin <input type="radio"/> Barbiturates, sedatives, or sleeping pills <input type="radio"/> Sulfa drugs <input type="radio"/> Codeine or other narcotics <input type="radio"/> Latex <input type="radio"/> Iodine <input type="radio"/> Hay fever/seasonal <input type="radio"/> Animals <input type="radio"/> Food (specify): <input type="radio"/> Metals (specify): <input type="radio"/> Other (specify):	
Abnormal bleeding (not in gums)				Glaucoma					
AIDS or HIV infection				Hemophilia Glaucoma					
Anemia				Hepatitis					
Arthritis				Recurrent Infections. If yes, indicate type of infection:					
Rheumatoid arthritis									
Asthma				Kidney problems					
Blood transfusion. If yes, date:				Mental health disorders. If yes, specify:					
Cancer/Chemotherapy/Radiation therapy									
Cardiovascular disease. If yes, check all that apply below:				Malnutrition					
				Night sweats					
				Neurological disorders. If yes, specify:					
<input type="radio"/> Angina <input type="radio"/> Arteriosclerosis <input type="radio"/> Artificial heart valves <input type="radio"/> Congenital heart defects <input type="radio"/> Congestive heart failures <input type="radio"/> Coronary artery disease <input type="radio"/> Damaged heart valves <input type="radio"/> Heart attack <input type="radio"/> High blood pressure <input type="radio"/> Low blood pressure <input type="radio"/> Mitral valve prolapse <input type="radio"/> Pacemaker <input type="radio"/> Rheumatic heart disease <input type="radio"/> Heart Murmur				Osteoporosis <i>**Because your are taking a type of drug called a bisphosphonate, you may be at risk for developing osteonecrosis of the jaw and certain dental treatments may increase that risk.***</i>				How Did You Hear About Our Office? <i>(Circle All That Apply)</i> <input type="checkbox"/> Website? <input type="checkbox"/> Insurance Company? <input type="checkbox"/> Referring Doctor? <input type="checkbox"/> Newspaper? <input type="checkbox"/> Friend/Family Member? <input type="checkbox"/> Former Patient? <input type="checkbox"/> Other?	
				Persistent swollen glands in neck					
				Respiratory problems. IF yes, specify: -Emphysema -Bronchitis, etc.					
				Severe headache/migraines					
				Severe or rapid weight loss					
				Sexually transmitted disease					
				Sinus trouble					
				Sleep disorder					
				Sores or ulcers in the mouth					
				Stroke					
				Systemic lupus erythematosus					
	High Cholesterol				Tuberculosis				
	Chest pain upon exertion				Thyroid problems				
Chronic pain				Excessive urination:					
Disease, drug or radiation-induced immunosuppression				Are you a Smoker:					
				Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:					
Diabetes. If yes, circle type: 1 2									
Dry Mouth									
Eating disorder. If yes specify:									
Epilepsy									
Fainting spells or seizures									
Gastrointestinal disease									
G.E. Reflux/persistent heartburn									

Note: Both doctor and patient is encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above, I acknowledge that my questions, if any, about 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 action they take or do not take because of errors or omissions I may have made in the completion of this form.

Print Patient Name

Patient Signature (if under 18, must be signed by parent)

Date

FOR COMPLETION BY DENTIST

Reviewed by:

Date:

Significant findings:

Dental Phobia Status:

ASA Status:

Health History updated on: