Mark Arooni DDS

skill / passion / technology / ridiculously indulgent service

About You

Today's Date:

Email Address:

Name:

I prefer to be called: ☐ Male ☐ Female

Birthdate: Age: SS#

Home Address: Apt / Condo:

City: State: Zip:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home #: ( ) Pager / Cell #: ( )

Work #: ( ) Ext: DL #:

Employer:

Employer's Address:

City: State: Zip:

How long there? Occupation:

Where and when are the best times to reach you?

Whom may we thank for referring you?

Previous / Present Dentist:

Last Visit Date:

Spouse Information

His / Her Name

Employer

Work # ( ) Ext: SS#

Birthdate: DL #

Person Responsible for Account

Work # ( ) Ext: Home # ( )

Billing Address

Relation SS #

Employer DL #

Dental Insurance

Primary Dental Insurance

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone #: ( )

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: Insured's SS #:

Insured's Employer:

Employer Address:

Secondary Dental Insurance

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone #: ( )

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthday: Insured's SS #:

Insured's Employer:

Employer Address:

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: Relation:

Work #: ( ) Home #: ( )

Medical History

Physician's Name:

Work #: ( ) Date of last visit:

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:

Medical History continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription / over-the-counter or supplement drugs? ☐ Yes ☐ No

Please list each one _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you ever taken Phen-Fen (Also known as Redux or Pondimin) ☐ Yes ☐ No

If so, when? _____

For Women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following disease or medical problems? *(Please circle option that applies)*

Y	N		Y	N	
☐	☐	Anemia / Radiation Treatment	☐	☐	Hemophilia /Abnormal Bleeding
☐	☐	Artificial Bones / Joints / Valves	☐	☐	Hepatitis (circle one) A B C
☐	☐	Arthritis	☐	☐	High / Low Blood Pressure
☐	☐	Asthma	☐	☐	HIV+ / AIDS
☐	☐	Blood Transfusion	☐	☐	Hospitalized for any reason
☐	☐	Cancer /Chemotherapy	☐	☐	Kidney Problems
☐	☐	Congenital Heart Defect	☐	☐	Mitral Valve Prolapse
☐	☐	Diabetes	☐	☐	Psychiatric Problems
☐	☐	Difficulty Breathing	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Drug / Alcohol Abuse	☐	☐	Severe / Frequent Headaches
☐	☐	Emphysema / Glaucoma	☐	☐	Shingles
☐	☐	Epilepsy / Seizures / Fainting Spells	☐	☐	Sickle Cell Disease / Traits
☐	☐	Fever Blisters / Herpes	☐	☐	Sinus Problems
☐	☐	Heart Attack / Stroke	☐	☐	Tuberculosis (TB)
☐	☐	Heart Murmur	☐	☐	Ulcers / Colitis
☐	☐	Heart Surgery / Pacemaker	☐	☐	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Codeine	☐	☐	Jewelry / Metals	☐	☐	Tetracycline
☐	☐	Dental Anesthetics	☐	☐	Latex	☐	☐	Other

Please list any other drugs / materials that you are allergic to:

_____

Dental History

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment recommended by your medical doctor? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Initials : _____ Date: _____

Medical History Update

Date: Comments: Signature: _____

Date: Comments: Signature: _____

Date: Comments: Signature: _____

Date: Comments: Signature: _____

Date: Comments: Signature: _____