# Welcome to our Office

## Dr. Berge Najarian DDS

### PATIENT INFORMATION

Name: ______ Last ______ First ______ M ______ Nickname: ______

Birthdate: ______ Age: ______ Sex: MALE / FEMALE SSN: ______ Phone # ______

Marital Status: SINGLE / MARRIED / DIVORCED / WIDOWED Email: ______

Address: ______ City/State: ______ ZIP: ______

Employer: ______ Occupation: ______ Work Phone # ______

Employer Address: ______ City/State: ______ ZIP: ______

Best time to reach you: ______ How did you hear about us?: ______

General Dentist: ______ Last visit date: ______ Office # ______

### SPOUSE INFORMATION

His/Her Name: ______ Last ______ First ______ Birthdate: ______

Employer: ______ Work Phone # ______ SSN: ______

### INSURANCE INFORMATION

Orthodontic Coverage: YES / NO Dental Coverage: YES / NO Insurance Co. Name: ______

Insurance Co. Address: ______ Insurance Co. Phone # ______

Insured's Name: ______ Relation: ______ Birthdate: ______

Insured's ID # ______ Insured's Employer: ______

### SECONDARY INSURANCE INFORMATION

Orthodontic Coverage: YES / NO Dental Coverage: YES / NO Insurance Co. Name: ______

Insurance Co. Address: ______ Insurance Co. Phone # ______

Insured's Name: ______ Relation: ______ Birthdate: ______

Insured's ID # ______ Insured's Employer: ______

### RESPONSIBLE PARTY IF OTHER THAN THE PATIENT

Full Name: ______ SSN: ______ Birthdate: ______

### IN CASE OF EMERGENY CONTACT

Name: ______ Relation: ______ Phone # ______

### PRIMARY CARE PHYSICIAN

Name: ______ Phone # ______ Last Visit: ______

## MEDICAL HISTORY

**Your current physical health is:** GOOD / FAIR / POOR **Currently under the care of a physician?** YES / NO

**Please Explain:** ____________________

**Are you taking any prescription/over-the-counter drugs?** YES / NO **Please list:** ____________________

**For Women: Are you using a prescribed method of birth control?** YES / NO **If yes, which one?** ____________________

**Are you pregnant?** YES / NO **If yes, what week #** __________ **Are you nursing?** YES / NO

## HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

| | | | |
|---|---|---|---|
| **Y / N** Abnormal Bleeding | **Y / N** Emphysema | **Y / N** HIV+/AIDS | **Y / N** Sinus Problems |
| **Y / N** Anemia | **Y / N** Epilepsy/Seizures/Fainting | **Y / N** Hospitalized for Any Reason | **Y / N** Tuberculosis (TB) |
| **Y / N** Artificial Bones/Joints/Valves | **Y / N** Fever Blisters/Herpes | **Y / N** Kidney Problems | **Y / N** Ulcers/Colitis |
| **Y / N** Asthma/Arthritis | **Y / N** Glaucoma | **Y / N** Mitral Valve Prolapse | **Y / N** Venereal Disease |
| **Y / N** Blood Transfusion | **Y / N** Heart Attack/Stroke | **Y / N** Psychiatric Problems | **List any serious medical** |
| **Y / N** Cancer/Chemotherapy | **Y / N** Heart Murmur | **Y / N** Radiation Treatment | **conditions you've ever had:** |
| **Y / N** Congenital Heart Defect | **Y / N** Heart Surgery/Pacemaker | **Y / N** Rheumatic/Scarlet Fever | __________ |
| **Y / N** Diabetes | **Y / N** Hemophilia | **Y / N** Severe/Frequent Headaches | __________ |
| **Y / N** Difficulty Breathing | **Y / N** Hepatitis | **Y / N** Shingles | __________ |
| **Y / N** Drug/Alcohol Abuse | **Y / N** High/Low Blood Pressure | **Y / N** Sickle Call Disease/Traits | __________ |

## ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

| | | | |
|---|---|---|---|
| **Y / N** Asprin | **Y / N** Codeine | **Y / N** Erythromycin | **Y / N** Penecilin |
| **Y / N** Any Metals/Plastics | **Y / N** Dental Anesthetics | **Y / N** Latex | **Y / N** Tetracycline |

**Y / N** Other If yes, please list each one: ____________________

## DENTAL HISTORY

**What are the main concerns you'd like orthodontics to accomplish?** ____________________

**Have you ever been evaluated for orthodontic treatment?** 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

**Your current dental health is:** GOOD / FAIR / POOR **Like your smile?** YES / NO **Gums ever bleed?** YES / NO

**Have you ever had an injury to your:** MOUTH / TEETH / CHIN **Speech Problems?** ____________________

**Do you generally breathe through your mouth?** YES / NO **If yes:** While Awake? / While Asleep?

**Do you have any missing or extra permanent teeth?** YES / NO **Do you smoke or use tobacco?** YES / NO

**Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate?** YES / NO

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

I understand that this office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying of the group insurance benefits (otherwise payable to me) directly to this office.

____________________

Signature Date

**OFFICE USE ONLY! OFFICE USE ONLY! OFFICE USE ONLY!**

*I verbally reviewed the medical/dental information above with the patient named.* Initial: __________ Date: __________

Notes: ____________________