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Dr. Jim Yeganegi Inc. & Associates

PATIENT INFORMATION

Date: ☐ New Patient ☐ Update

Patient:

Last Name | First Name | Middle Name | Preferred Name | Title

☐ Male ☐ Female ☐ Child* ☐ Student** ☐ English ☐ French ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common-law ☐ Separated

*If child, provide parent/guardian name(s) below:

Parent/Guardian Name(s)

**If student, please complete: ☐ Full-time ☐ Part-time

School/Location

Patient Date of Birth: / / mm/dd/yyyy

Address:

Address Line 1

Address Line 2

City | Prov | Postal Code

E-Mail:

Home:

Cell:

Work: Ext:

Other:

Fax:

How did you hear about us? ☐ Website ☐ Friend/family ☐ Walk-in ☐ Other

Preferred Contact Method: ☐ Home ☐ Work ☐ Cell ☐ E-Mail

Whom may we thank for this referral:

INSURANCE INFORMATION

Primary Insurance Carrier:

Subscriber:

First Name | Last Name | Preferred Name

Subscriber Date of Birth: / / mm/dd/yyyy

Subscriber Employer:

Group/Plan Number:

Identification Number:

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Coverage: ☐ Single ☐ Family Basic: Major: Ortho:

Secondary Insurance Carrier:

Subscriber:

First Name | Last Name | Preferred Name

Subscriber Date of Birth: / / mm/dd/yyyy

Subscriber Employer:

Group/Plan Number:

Identification Number:

Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Coverage: ☐ Single ☐ Family Basic: Major: Ortho:

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MEDICAL HISTORY

Physician: ..... Specialty: ..... Telephone: .....

Most recent exam: ..... Purpose: .....

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

DO YOU HAVE OR HAVE YOU EVER HAD:

TO BE FILLED OUT BY OFFICE ASA _____ (1-6) ☐ ☐ ☐

1. hospitalization for illness or injury..... ☐Y☐N
2. an allergic reaction to:
   - ☐ASPIRIN, IBUPROFEN, ACETAMINOPHEN, CODEINE
   - ☐PENICILLIN
   - ☐LOCAL ANESTHETIC
   - ☐FLUORIDE
   - ☐ERYTHROMYCIN
   - ☐METALS (NICKEL, GOLD, SILVER, _____)
   - ☐TETRACYCLINE
   - ☐LATEX
   - ☐SULFA
   - ☐OTHER _____
3. heart problems / cardiac stent in the last six months ☐Y☐N
4. history of infective endocarditis..... ☐Y☐N
5. artificial heart valve, repaired heart defect (PFO)..... ☐Y☐N
6. pacemaker or implantable defibrillator..... ☐Y☐N
7. orthopedic implant (joint replacement)..... ☐Y☐N
8. rheumatic or scarlet fever..... ☐Y☐N
9. high or low blood pressure..... ☐Y☐N
10. a stroke (taking blood thinners)..... ☐Y☐N
11. anemia or other blood disorders..... ☐Y☐N
12. prolonged bleeding due to a slight cut (INR > 3.5).. ☐Y☐N
13. emphysema, shortness of breath or sarcoidosis.... ☐Y☐N
14. tuberculosis, measles or chickenpox..... ☐Y☐N
15. asthma..... ☐Y☐N
16. breathing or sleep problems..... ☐Y☐N
    (i.e. sleep apnea, snoring, sinus) ☐Y☐N
17. kidney disease..... ☐Y☐N
18. liver disease..... ☐Y☐N
19. jaundice..... ☐Y☐N
20. thyroid, parathyroid disease or calcium deficiency. ☐Y☐N
21. hormone deficiency..... ☐Y☐N
22. high cholesterol or taking statin drugs..... ☐Y☐N
23. diabetes (HbA1c= _____)..... ☐Y☐N
24. stomach or duodenal ulcer..... ☐Y☐N
25. digestive disorders..... ☐Y☐N
    (i.e. celiac disease, gastric reflux)
26. osteoporosis/osteopenia..... ☐Y☐N
    (i.e. taking bisphosphonates)
27. arthritis..... ☐Y☐N
28. autoimmune disease..... ☐Y☐N
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma..... ☐Y☐N
30. contact lenses..... ☐Y☐N
31. head or neck injuries..... ☐Y☐N
32. epilepsy, convulsions (seizures)..... ☐Y☐N
33. neurologic disorders (ADD/ADHD, prion disease)..... ☐Y☐N
34. viral infections and cold sores..... ☐Y☐N
35. any lumps or swelling in the mouth..... ☐Y☐N
36. hives, skin rash, hay fever..... ☐Y☐N
37. STI / STD / HPV..... ☐Y☐N
38. hepatitis (type _____)..... ☐Y☐N
39. HIV / AIDS..... ☐Y☐N
40. tumor, abnormal growth..... ☐Y☐N
41. radiation therapy..... ☐Y☐N
42. chemotherapy, immunosuppressive meds.... ☐Y☐N
43. emotional difficulties..... ☐Y☐N
44. psychiatric treatment..... ☐Y☐N
45. antidepressant medication..... ☐Y☐N
46. alcohol / recreational drug use..... ☐Y☐N

ARE YOU:

47. presently being treated for any other illness... ☐Y☐N
48. aware of a change in your health in the last 24 hours..... ☐Y☐N
    (i.e. fever, chills, new cough, or diarrhea)
50. taking dietary supplements..... ☐Y☐N
51. often exhausted or fatigued..... ☐Y☐N
52. experiencing frequent headaches..... ☐Y☐N
53. a smoker, smoked previously or use smokeless tobacco..... ☐Y☐N
54. considered a touchy / sensitive person..... ☐Y☐N
55. often unhappy or depressed..... ☐Y☐N
56. FEMALE – taking birth control pills..... ☐Y☐N
57. FEMALE – pregnant..... ☐Y☐N
58. MALE – prostate disorders..... ☐Y☐N

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

.....

List all medications, supplements, and/or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN FUTURE OF ANY CHANGES TO YOUR HEALTH OR OF ANY MEDICATIONS YOU MAY BE TAKING.

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DENTAL HISTORY

Previous Dentist: _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam: / / MM/DD/YYYY Date of most recent x-rays / / MM/DD/YYYY

Date of most recent treatment (other than a cleaning) : / / MM/DD/YYYY

I routinely see my dentist every: ■ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

HOW WOULD RATE THE CONDITION OF YOUR MOUTH?: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	☐ ☐ ☐	*
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ]		☐Y☐N
2. Have you had an unfavorable dental experience?		☐Y☐N
3. Have you ever had complications from past dental treatment?		☐Y☐N
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?		☐Y☐N
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?		☐Y☐N
6. Have you had any teeth removed?		☐Y☐N
GUM AND BONE	☐ ☐ ☐	*
7. Do your gums bleed or are they painful when brushing or flossing?		☐Y☐N
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?		☐Y☐N
9. Have you ever noticed an unpleasant taste or odor in your mouth?		☐Y☐N
10. Is there anyone with a history of periodontal disease in your family?		☐Y☐N
11. Have you ever experienced gum recession?		☐Y☐N
12. Have you ever had any teeth become loose on their own (without an injury), or difficulty eating apples?		☐Y☐N
13. Have you experienced a burning sensation in your mouth?		☐Y☐N
TOOTH STRUCTURE	☐ ☐ ☐	*
14. Have you had any cavities within the past 3 years?		☐Y☐N
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?		☐Y☐N
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?		☐Y☐N
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?		☐Y☐N
18. Do you have grooves or notches on your teeth near the gum line?		☐Y☐N
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?		☐Y☐N
20. Do you frequently get food caught between any teeth?		☐Y☐N
BITE AND JAW JOINT	☐ ☐ ☐	*
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)		☐Y☐N
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?		☐Y☐N
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?		☐Y☐N
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?		☐Y☐N
25. Are your teeth becoming more crooked, crowded, or overlapped?		☐Y☐N
26. Are your teeth developing spaces or becoming more loose?		☐Y☐N
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together?		☐Y☐N
28. Do you place your tongue between your teeth or close your teeth against your tongue?		☐Y☐N
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?		☐Y☐N
30. Do you clench your teeth in the daytime or make them sore?		☐Y☐N
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth?		☐Y☐N
32. Do you wear or have you ever worn a bite appliance?		☐Y☐N
SMILE CHARACTERISTICS	☐ ☐ ☐	*
33. Is there anything about the appearance of your teeth that you would like to change?		☐Y☐N
34. Have you ever whitened (bleached) your teeth?		☐Y☐N
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth?		☐Y☐N
36. Have you been disappointed with the appearance of previous dental work?		☐Y☐N

I certify that the above history has been completed to the best of my knowledge.

Signature: _____