Los Robles General & Cosmetic Dental Center

415 Rolling Oaks Dr. Suite 120 | Thousand Oaks, CA 91361
Phone: 805-449-9952 **Fax:** 805-449-1189
www.BeautifulDental.com

PATIENT INFORMATION

Last Name:	First Name:	Nickname:		Date of Birth:
Address:	City:	State:	ZIP code:	Sex: Male Female
Email:	Social Security No: (For Insurance Verification)	Mobile Phone:		
The Reason for your Visit Today: (Toothache, estimate, etc.)	Occupation:	Work Phone:		

Primary Insurance

Primary Insurance Co Name:		Phone #:	
Insurance Co. Address:	City:	State:	Zip Code:
Subscriber's Full Name:	Relationship to Patient:		DOB:
Subscriber's Address:	City:	State:	Zip Code:
Subscriber ID #	Group #		
Employer:	Work Phone #		

Secondary Insurance

Primary Insurance Co Name:			
Insurance Co. Address:	City:	State:	Zip Code:
Subscriber's Full Name:	Relationship to Patient:		DOB:
Subscriber's Address:	City:	State:	Zip Code:
Subscriber ID #	Group #		
Employer:	Work Phone #		

In Case of emergency, please Call:_____ Phone # _____

I hereby authorize the release of any information including the diagnosis and the records of any treatment, or examination rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and the reimbursement, directly to the dentist, of insurance benefits under which I am entitled. Authorization is hereby granted to Equifax and Mojgan Hashemi, D.D.S to release information for appropriate credit Verification and patient information required.

_____ Initials I ACKNOWLEDGE OF RECEIPTS OF A COPY OF THIS OFFICE'S **NOTICE OF PRIVACY PRACTICES** SHEET.

_____ Initials I ACKNOWLEDGE OF RECEIPTS OF A COPY OF THE **2021 DENTAL MATERIAL FACTS SHEET** AS REQUARED BY LAW.

_____ _____ _____

Signature of patient (or responsible party) **Print Name** **Date**

PATIENT HEALTH HISTORY

Name _____

Date of last Medical Exam: _____

How would you describe your health? _____Excellent ____ Very Good ____ Good ____ Fair _____Others: Please describe? _____

Do you have a Medical Physician? ___No ___Yes: Name of Physician _____ Tel. # _____

1. Are you now or have you been under the care of a physician within the past five years? ____No ___Yes If so, why? _____
2. Have you had any major surgery or hospitalization? _____No ___Yes. Describe: _____ When: _____
3. Are you now or have you recently been taking any medication? If so, for what? _____
4. Are you taking a bisphosphonate medication for osteoporosis (Fosamax, Actonel, Boniva, or IV Bisphosphnates)? _____No ____Yes
5. Are you allergic to or have any reactions to any of the following:

	Y	N		Y	N		Y	N
Local Anesthetics (e.g. Novocain)			Aspirin			Iodine		
Penicillin or any other antibiotics			Codeine			Latex rubber		
Sulfa Drugs			Barbiturates			Others (please list)		
Any metals(e.g. nickel, mercury)			Sedatives					

6. WOMEN ONLY:

	Y	N
a) Are you pregnant or think you may be pregnant?		
b.) Are you nursing?		
c.) Are you practicing birth control medication?		

7. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

	Y	N		Y	N		Y	N		Y	N
Heart Attack			Joint Replacement/Implant			Epilepsy or Seizures			Gonorrhea		
Heart Failure			Kidney Trouble			Glaucoma			Cold Sores		
Heart Surgery			Ulcers			Pain in Jaw Joints			Genital Herpes		
Heart Disease			Arthritis			Aids or HIV Infection			Fainting/Dizzy Spells		
Angina Pectoris			Emphysema			Liver Disease			Nervousness		
Heart Murmur			Tuberculosis			Hepatitis A (infectious)			Psychiatric Treatment		
High Blood Pressure			Asthma			Hepatitis B (serum)			Sickle Cell Disease		
Rheumatic Fever			Hay Fever/Allergies			Hepatitis C			Bleeding Gums		
Congenital Heart Defect			Sinus Trouble			Yellow Jaundice			Tooth Pain		
Scarlet Fever			Diabetes			Blood Transfusion			Bad Breath		
Artificial Heart Valve			Thyroid Disease			Drug Addiction			Chronic Headaches		
Mitral Valve Prolapsed			Radiation Therapy			Hemophilia			Chronic Neck Aches		
Heart Pace Maker			Chemotherapy			Syphilis			Cosmetic Surgery		
Stroke			Cancer			Leukemia			Cortisone Medicine		
Others not listed:											

PATIENT DENTAL HISTORY

Name of previous Dentist and Location: _____ Date of Last Exam: _____

	Y	N		Y	N
1. Do your gums bleed while brushing or flossing?			8. Do you have frequent headaches?		
2. Are your teeth sensitive to hot or cold liquids/foods?			9. Do you clench or grind your teeth?		
3. Are your teeth sensitive to sweet or sour liquids/foods?			10. Do you bite your lips or cheeks frequently?		
4. Do you feel pain to any of your teeth?			11. Have you ever had any difficulty with extractions in the past?		
5. Do you have any sores or lumps in or near your mouth?			12. Have you had any orthodontic treatment?		
6. Have you had any head, neck or jaw injuries?			13. Have you ever had any prolonged bleeding following extractions?		
7. Have you ever experienced any of the following Problems in your jaw? a) Clicking			14. Do you wear dentures or partials? If yes, date of placement:		
b) Pain (joint, ear, side of face)			15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
c) Difficulty in opening or closing			16. Do you like your smile?		
d) Difficulty in chewing			17. Interested in aligning your teeth with *Invisalign*?		

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including The diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party Payers and/or health practitioners.

Signature of Patient/Parent or Guardian: _____ Date _____

Doctor's Signature: _____ Date _____