Dr. Foroud Tale-Yazdi
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Patient Information

Patient Name: _____ Date:_____ ☐ Male ☐ Female
Last First MI
☐ Married ☐ Single ☐ Child ☐ Other_____ Social Security #: _____ Birth Date: _____
Phone (Home) :_____ (Work): _____ Ext:_____ Cell:_____ Email:_____
Address: _____
Street Apartment # City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ Patient is responsible for payment

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Address: _____
Street Apartment # City State Zip code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ ***Occupation:*** _____

Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured: _____ **Dental INS Company:** _____
Last First MI
Insured's Birth Date: _____ **ID #:** _____ **Group#:**_____
Address Same As Above ☐ Yes ☐ No

Insured's Address: _____
Street City State Zip Code
Employer Same as Above ☐ Yes ☐ No
Insured's Employer Name: _____

Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary
Name of Insured: _____ **Dental INS Company:** _____
Last First MI
Insured's Birth Date: _____ ID #: _____ Group #: _____
Insured's Employer Name: _____
Address: _____
Street City State Zip Code
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Insurance Company
☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School/ Work ☐ Internet ☐
Other_____
Name of person or office referring you to our practice: _____

Health Information

Have you ever had any of the following? Please check those that Apply:

- ☐ AIDS
- ☐ Allergies/Hives
- ☐ Allergies to Metals
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cold Sores
- ☐ Congenital Heart Lesion
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Difficulty in Swallowing
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells or Seizures
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Ailments or Attack / Failure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis or Jaundice
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Mitral Valve Prolepses
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Pregnancy
  Due date:_____
- ☐ Psychiatric Treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems/ Disease
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any serious illness or operation or been hospitalized? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you taking any Medication?
  If yes, what? _____What dosage? _____
- Have you ever been premeditated with antibiotics for your dental treatment? ☐ Yes ☐ No
- Are you sensitive or allergic to any drugs or materials? ☐ Penicillin ☐ Tetracycline ☐ Erythromycin ☐ Aspirin ☐ Codeine ☐ Latex
- Do you take birth control pills? ☐ Yes ☐ No

Dental History

- Do you have a specific dental problem or chief complaint? Describe:_____ ☐ Yes ☐ No
- Do you have dental examinations on a routine basis? When was your last visit? _____ ☐ Yes ☐ No
- Do you think you have cavities or gum disease?_____ ☐ Yes ☐ No
- Do you brush & floss on a routine basis? Describe:_____ ☐ Yes ☐ No
- Do your gums ever bleed? Describe:_____ ☐ Yes ☐ No
- Do you like your smile? ☐ Yes ☐ No
- Do you want to keep your remaining teeth? ☐ Yes ☐ No
- Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ☐ Yes ☐ No
- Have your past experiences in a dental office been positive? ☐ Yes ☐ No
- Name of previous dentist? _____Date of last full month x-ray series

Disclaimer

I understand that the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical & insurance status. I also understand that this information will be held in the strictest of confidential. I authorize the dental team to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Since payment is due in full at the time of treatment (unless other arrangements have been approved), I am responsible for any amount not covered by my insurance 90days, I agree to pay all costs associated with collections agency; I agree to pay all cost associated with collections and attorney fee if suit be instituted hereunder. I understand that a return check will result in a $30 fee. If I need to reschedule my appointment, I will do everything within my power to give at least a 24 hour notice. I realized that failure to do so may result in a $25 fee.

Signature _____ Date _____

Privacy Practices

Foroud Tale-Yazdi, D.D.S.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I _____, Understand that Dr. Tale-Yazdi's Offices abides by the HIPAA Law and will protect the privacy of my personal information.

Please Print Name _____Signature _____ Date_____