D|R Dental Associates

Yeganeh Rezaie, DMD | Armin Daee, DMD

PATIENT INFORMATION

Title_____ Last Name _____ First Name _____ MI ___ Nickname _____

Date of Birth_____ Age_____ Marital Status_____ Sex_____

Address _____ City_____ State_____ Zip_____

Home Phone #_____ Cell #_____ Email_____

Health Care Guardian Name_____ Health Care Guardian Phone #_____

Emergency Contact_____ Emergency Phone #_____

Driver Lic #_____ SSN _____

Occupation_____ Employer_____ Referred By_____

Is patient responsible for paying bills? Yes_____ No_____ (if No please provide information)

Financial Responsible Party: Name_____ Date of Birth _____

Phone Number_____ Address_____ SSN_____

Do you have Dental Insurance? Yes___ No____ (If yes please provide information)

Insurance Name_____ Group Number/Name_____ Employer_____

Subscriber/Policy Holder Name _____ Subscriber ID _____ DOB_____

Relationship to Patient _____ Insurance Phone Number_____

If you have a Secondary Dental Insurance please provide information here:

_____

7737 N University Dr Suite 209| Tamarac FL 33321 Tel: (954) 721-2581 | Fax: (954) 721-9067

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HEALTH HISTORY FORM

Name_____ **Date of Birth**_____ **Gender**_____ **Today's Date**_____

MEDICAL HISTORY

Have there been any changes in your general health in the past year? Yes / No please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam? _____

Name of physician_____ **Physician phone number**_____

Do you have, or have you ever had, any of the following conditions:

- ○ Congenital heart disease
- ○ Cardiovascular disease
- ○ Heart attack
- ○ Heart murmur
- ○ Coronary artery disease
- ○ Chest pain
- ○ High/low blood pressure
- ○ Stroke
- ○ Irregular heartbeat
- ○ Heart surgery
- ○ Pacemaker
- ○ Heart valve
- ○ Bleeding tendency
- ○ Blood transfusion
- ○ Bruise easily
- ○ Liver disease
- ○ Jaundice
- ○ Hepatitis A, B, or C
- ○ Diabetes
- ○ Surgery _____

- ○ Glaucoma
- ○ Osteoporosis
- ○ Osteopenia
- ○ Arthritis
- ○ Implants
- ○ Hip/ knee replacement
- ○ AIDS/HIV
- ○ Herpes
- ○ Fever blister
- ○ Mouth ulcers
- ○ Lung disease
- ○ Asthma
- ○ Emphysema
- ○ COPD
- ○ Chronic or severe cough
- ○ Bronchitis
- ○ Pneumonia
- ○ Tuberculosis
- ○ Shortness of breath

- ○ Anemia
- ○ Bleeding disorder
- ○ Kidney disease
- ○ Dialysis
- ○ Dizziness/ Vertigo
- ○ Ear infection
- ○ Sinus /nasal problems
- ○ Sleep apnea
- ○ Headaches/Migraines
- ○ Facial pain
- ○ Gastrointestinal
- ○ Stomach ulcers/ colitis
- ○ Thyroid disease
- ○ Cancer
- ○ Significant weight change
- ○ Epilepsy/Seizures
- ○ Mental health Issues
- ○ Depression
- ○ Hospitalization

Other _____

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

- ○ Sedatives or barbiturates
- ○ Codeine or other pain medication
- ○ Aspirin/ Ibuprofen (Motrin)/ Naproxen (Aleve)
- ○ Penicillin or other Antibiotics
- ○ Sulfa Drugs

- ○ Local anesthesia
- ○ Latex
- ○ Iodine
- ○ Food
- ○ Other (Please list here)

Patient's Name_____ Date of Birth_____

MEDICATIONS– Are you currently prescribed or taking any of the following:

- Antibiotics
- Anticoagulants or Blood Thinners
- Blood Pressure medication
- Heart Medication
- Steroids
- Antianxiety or Antidepressants
- Other (please list here) _____
- Cancer or Chemotherapy Drugs
- Prescription Pain Medication
- Aspirin / Motrin/ Aleve/ Ibuprofen
- Insulin or other anti-diabetic drug
- Bisphosphonates or other bone medication
- Supplements

Have you ever been advised to premedicate for a dental procedure? Yes /No

- **PHARMACY INFORMATION:** _____

ANESTHESIA HISTORY Have you had any problem associated with local anesthesia? Yes / No

FEMALE PATIENTS Are you pregnant, breastfeeding, or might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked vaped or chewed tobacco? Yes / No how long/ how often? _____

Do you drink Alcohol? Yes / No how often? _____ **Do you use any Recreational Drugs?** Yes / No

Have you ever sought professional care or been hospitalized for: Substance Abuse/ Alcoholism/ Other

DENTAL HISTORY

Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No please describe _____

Are you having any dental discomfort at this time? Yes / No please describe _____

Have you had any adverse effects from dental treatment? Yes / No please describe _____

Date of last dental visit? _____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

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I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____

Signature of patient, parent, guardian Print Name Date

_____

Doctor's Signature **Comments** **Date**

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Acknowledgement of Receipt of
HIPAA Notice of Privacy Practices

I acknowledge that I have received and read the attached HIPAA Notice of Privacy Practices.

_____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

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