Amidi Dental

Family & Cosmetic Dentistry
1039 El Monte Ave., #E • Mountain View, CA 94040 • (650) 988-6500

Patient Registration and History Form

Patient Information

Today's Date _____

Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ **Gender** ☐ Male ☐ Female Date of Birth _____ Age _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

E-mail _____ Best time & way to reach you? _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT (specify someone who does not live in your household)

Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

Employer / School Information

Name _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Phone _____ Ext _____

Spouse Information

Last Name _____ First Name _____ Middle Initial _____

Marital Status ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Partnered for _____ years

Social Security # _____ Date of Birth _____ Age _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

Spouse's Employer _____

Dental Insurance Information

Who is responsible for the account? _____ Relationship to Patient _____

Insurance Company _____ Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____ Relationship to Patient _____

Insurance Company _____ Group # _____

Social Security # _____ Date of Birth _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Maryam Amidi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative
Signature of Patient, Parent, Guardian or Personal Representative

Date _____ Relationship to Patient _____

Dental History

Reason for today's visit _____

Former dentist _____ City _____ State _____

Date of last dental visit _____ Date of last dental X-rays _____

How often do you brush? _____ How often do you floss? _____

Please check either the "Yes" or "No" box to indicated if you have had any of the following conditions:

Bad breath	☐ Yes	☐ No	Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Food collecting between teeth	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Grinding teeth	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Gums swollen or tender	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Chew on one side mouth	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Mouth pain when brushing	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No	Sores or growths in your mouth	☐ Yes	☐ No			

Health History

Physician's Name _____ Date of last doctor's visit _____

Do you wear contact lenses? ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen" [these include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)]? ☐ Yes ☐ No

Women:

Taking birth control pills? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No Due date _____

Please check the box if you are allergic to any of the following:

☐ Aspirin ☐ Iodine ☐ Penicillin ☐ Barbiturates (sleeping pills) ☐ Other _____

☐ Codeine ☐ Latex ☐ Sulfa ☐ Local anesthetic ☐ Other _____

Please list any medications you are currently taking and the correlating diagnosis:

_____

Pharmacy Name _____ Phone _____

Please check either the "Yes" or "No" box to indicated if you have had any of the following conditions:

AIDS/HIV	☐ Yes	☐ No	Congenital heart lesions	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Sinus trouble	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Cortisone treatments	☐ Yes	☐ No	Jaw pain	☐ Yes	☐ No	Skin rash	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Cough, persistent/bloody	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No	Special diet	☐ Yes	☐ No
Artificial heart valves	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Artificial joints	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No	Swollen feet/ankles	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No	Swollen neck glands	☐ Yes	☐ No
Back problems	☐ Yes	☐ No	Fainting / dizziness	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No	Thyroid problems	☐ Yes	☐ No
Bleeding abnormally (extractions/surgery)	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
			Headaches	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Heart murmur	☐ Yes	☐ No	Radiation treatment	☐ Yes	☐ No	Tumor/growth on head/neck	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Heart problems	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No			
Chemical dependency	☐ Yes	☐ No	Hepatitis type _____	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Scarlet fever	☐ Yes	☐ No	Venereal disease	☐ Yes	☐ No
Circulatory problems	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No	Shortness of breath	☐ Yes	☐ No	Weight loss	☐ Yes	☐ No

Doctor's signature _____ Date _____