Kamyar Negari, D.D.S.

14495 S. Bascom Avenue
Los Gatos, CA 95032
Tel: (408)377-8302

PATIENT INFORMATION...

❑Mr. ❑Mrs . ❑Ms . ❑Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: ❑Male ❑Female Birth Date _____ Age _____ Soc. Sec: _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home T el. _____ Cell . _____ Have you ever been a patient of our practice? ❑Yes ❑No

Referring Dentist _____ Medical Doctor _____ (FIRST NAME) _____ (LAST NAME)

Employer _____ Bus . Tel . _____ Ext . _____

In case of emergency, please contact _____ Tel . _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.#: _____ Birth Date _____ Age _____ Tel. _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. _____

INSURANCE INFORMATION...

Student: ..... ❑ Full Time ❑ Part Time ❑ Not ..... School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: .. ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY DENTAL INSURANCE CO...

Employer _____

Bus . Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus . Tel . _____ Plan _____

Ins . Co . Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel. _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑M ❑F Birth Date _____ S.S. # _____

Street _____ City _____

State, Zip _____ Tel. _____

SECONDARY DENTAL INSURANCE CO...

Employer _____

Bus . Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus . Tel . _____ Plan _____

Ins . Co . Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY)

_____ (STATE) _____ (ZIP) Tel _____

Group # _____ Group Name _____

Insured Party _____ (FIRST NAME) _____ (LAST NAME) Relation _____

Sex: ❑M ❑F Birth Date _____ S. S . # _____

Street _____ City _____

State, Zip _____ Tel. _____

Dental History ...

Reason for today's visit _____ Former Dentist _____

City _____ State _____

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

Place a mark on "yes" or "no" to indicate if you have had any of the following.

Y	N		Y	N		Y	N	
❑	❑	Bad breath	❑	❑	Gums swollen or tender	❑	❑	Sensitivity when biting
❑	❑	Bleeding gums	❑	❑	Jaw pain or clicking or popping	❑	❑	Sore muscles of face
❑	❑	Blisters on lips or mouth	❑	❑	Pain around ear	❑	❑	Sores or growths in your mouth
❑	❑	Broken fillings or teeth	❑	❑	Loose teeth	❑	❑	Nervous about seeing a dentist
❑	❑	Chew on one side of mouth	❑	❑	Orthodontic treatment	❑	❑	Wear partials or dentures
❑	❑	Dental imp lants	❑	❑	Periodontal treatment	❑	❑	Would you like nitrous oxide ?
❑	❑	Dry Mouth	❑	❑	Sensitivity to cold			
❑	❑	Food collecting between teeth	❑	❑	Sensitivity to heat			
❑	❑	Grind or clench teeth	❑	❑	Sensitivity to sweets			

How often do you floss? _____ Per day

How often do you brush? _____ Per day

MEDICAL HISTORY...

Physician's Name / Office # _____ Date of last visit _____

	Y	N
Have you ever taken any of the group of drugs collectively referred to as :		
1) "fen-phen" these include combinations of Ionimin, Adipex, Fastin (phentermine), Pondimin (fenfluramine)	❑	❑
2) Bisphosphonates for bone loss or osteoporosis - Boniva, Fosamax, Evista, Fosamax, Boniva, Actonel IV Zometa, Reclast, Xgeva, Prolia, or Aredia	❑	❑

Place a mark on "yes" or "no" to indicate if you have had any of the following.

Y	N		Y	N		Y	N	
❑	❑	AIDS/HIV	❑	❑	Diabetes	❑	❑	Respiratory disease
❑	❑	Alcohol intolerance			Sugar level this morning _____	❑	❑	Rheumatic fever
❑	❑	Anemia	❑	❑	Emphysema	❑	❑	Scarlet fever
❑	❑	Arthritis, Rheumatism	❑	❑	Epilepsy	❑	❑	Seizures
❑	❑	Artificial heart valves	❑	❑	Fainting or dizziness	❑	❑	Shortness of breath
❑	❑	Periodontal treatment	❑	❑	Head aches	❑	❑	Sinus trouble
❑	❑	Artificial joints	❑	❑	Heart murmur	❑	❑	Skin rash or hives
		Date of surgery _____	❑	❑	Heart problems	❑	❑	Stroke
❑	❑	Asthma or Hay Fever	❑	❑	Hepatitis type _____	❑	❑	Swollen neck glands
❑	❑	Back problems	❑	❑	Herpes	❑	❑	Thyroid problems
❑	❑	Bleeding abnormally, with extractions or surgery	❑	❑	High blood pressure	❑	❑	Tuberculosis
			❑	❑	Jaw pain	❑	❑	Tumor or growth
❑	❑	Blood disease	❑	❑	Kidney disease	❑	❑	Ulcers
❑	❑	Cancer	❑	❑	Liver disease	❑	❑	Venereal Disease
❑	❑	Chemical dependency	❑	❑	Low blood pressure	❑	❑	Weight loss, unexplained
❑	❑	Chemotherapy	❑	❑	Mitral valve prolapse	❑	❑	X-ray exposure at work
❑	❑	Circulatory problems	❑	❑	Nervous problems	❑	❑	Do you wear contact lenses?
❑	❑	Congenital heart lesions	❑	❑	Neurological problems			**WOMEN**
❑	❑	Cortisone treatments	❑	❑	Pacemaker or Defibrillator	❑	❑	Pregnant? Due date _____
❑	❑	Cough, persistent or bloody	❑	❑	Psychiatric care	❑	❑	Are you nursing ?
			❑	❑	Radiation Treatment			

Is there any other health conditions which we should be aware of?

MEDICATION...

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	FOR WHAT CONDITION	MEDICATION	FOR WHAT CONDITION

ALLERGIES...

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Latex
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Codeine or other narcotics	❑	❑	Do you have any known allergies	❑	❑	Ibuprofen

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ X _____ X _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

Has there been any changes in your health history since your last visit? ❑Yes ❑No; if yes, for what conditions _____

X _____ X _____ X _____

Signature of patient (Parent or Guardian if Minor) **Reviewed by** **Date**

SIGNATURE

X _____ X _____ X _____ X _____

Signature of patient (Parent if Minor) **Date** **Dr's initails** **Date**

I acknowledge I have received a copy of the office **Notice of Privacy Practice.**

X _____ X _____

Signature of patient (Parent or Guardian if Minor) **Date**

I acknowledge I have received a copy of the **Dental Materials Fact Sheet** as required by law.

X _____ X _____

Signature of patient (Parent or Guardian if Minor) **Date**