Arlen Vartanian, D.D.S., Inc.

Creating Beautiful Smiles

DATE: ____________________

PATIENT REGISTRATION & CONSENT

(PLEASE PRINT)

Last name: ____________________ First name: ____________________ MI: ______

Marital status (please check one): ___Single ___Married ___Divorced ___Separated ___Widowed

Date of birth: ____________________ Driver's license number: ____________________

SSN: ____________________ Email address: ____________________

Home phone: ____________________ Cell: ____________________ Work Phone: ____________________

Address: ____________________ City: ____________________ State: ______ Zip: __________

Your employer: ____________________ May we contact you at work? .... ○ Yes ○ No

How did you hear about our practice?: ____________________ **Referring patient's name:** ____________________

Spouse's name: ____________________ Employer: ____________________

Spouse's work phone: ____________________ Cell: ____________________ Number of dependents: ______

Person financially responsible for dependents: ____________________

IN CASE OF EMERGENCY, CONTACT: ____________________ Phone: ____________________

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU: ____________________ Phone: ____________________

PLEASE COMPLETE THIS PORTION IF PATIENT IS A MINOR (UNDER 18)

Guardian Name: ____________________ Occupation: ____________________ SSN: ____________________

Employer: ____________________ Work Phone: ____________________

Work Address: ____________________ City: ____________________ State: ______ Zip: __________

Primary Insurance Information

Primary dental insurance company, including address: ____________________

____

Name of insured: ____________________

Group name/number: ____________________

If connected to a union, name of union/local #: ____________________

Secondary Insurance Information (if applicable)

Secondary dental insurance company, including address: ____________________

____

Name of insured: ____________________

Group name/number: ____________________

If connected to a union, name of union/local #: ____________________

I hereby grant authority to the dentist in charge of the patient whose name appears on this health history form to administer any mutually agreed upon treatment, and to administer such x-rays, sedatives, medications, therapy or anesthetics necessary and to perform such operations or procedures as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment. I also understand that all responsibility for payment for dental services provided by this office for mysel and/or my dependents is mine and is due and payable at the time services are rendered unless other arrangements have been made. In the event payment(s) are not received by the agreed upon date(s), I understand that a 1-1/2% finance charge (18% APR) may be added to my account. Lastly, I understand that, where appropriate, credit bureau reports may be obtained.

Signed: ____________________ **Date:** ____________________

Relationship if patient is a minor or physically or mentally handicapped: ____________________

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PATIENT MEDICAL HISTORY

Patient's name: ______________________ Date of birth: ____________

1. Are you having pain or discomfort at this time? ○ Yes ○ No
   If yes, please explain: ____________
2. Have you been a patient in a hospital in the past two years? ○ Yes ○ No
3. Have you been under the care of a medical doctor during the past two years? ○ Yes ○ No
   Physician's name: ____________ Physician's phone: ____________
4. Have you taken any medication or drugs in the past two (2) years? ○ Yes ○ No
   If yes, please list: ____________
5. Are you currently taking any medication or drugs? ○ Yes ○ No
   If yes, please list: ____________
6. When you exert yourself, do you have to stop because of chest pain, shortness of breath or tiredness? ○ Yes ○ No
7. Do your ankles swell during the day? ○ Yes ○ No
8. Do you use more than two pillows to sleep? ○ Yes ○ No
9. Have you lost or gained 10 pounds or more in the past year? ○ Yes ○ No
10. Do you ever wake from sleep and feel short of breath? ○ Yes ○ No
11. Are you on a special diet? ○ Yes ○ No
12. Are you taking Bisphosphonate (For Osteoporosis) Yes No

Do you have a personal history of any of the following? Please check Yes or No.

Condition		Condition		Condition		Condition	
A.I.D.S./HIV Positive	○ Yes ○ No	Cold Sores	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Allergies/Hives	○ Yes ○ No	Congenital Heart Disease	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Anemia	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Heart Surgery	○ Yes ○ No	Stroke	○ Yes ○ No
Angina Pectoris	○ Yes ○ No	Developmentally Disabled	○ Yes ○ No	Hemophilia	○ Yes ○ No	Thyroid Problems	○ Yes ○ No
Arteriosclerosis	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A (Infectious)	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Arthritis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B (Serum)	○ Yes ○ No	Tumors	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Ulcers	○ Yes ○ No
Artificial Joints	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Jaundice	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting/Dizzy Spells	○ Yes ○ No	Kidney Trouble	○ Yes ○ No		
Blood Transfusion	○ Yes ○ No	Fhen-Phen Use	○ Yes ○ No	Liver Disease	○ Yes ○ No	Special Needs/Other	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Glaucoma	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	____________	
Cancer	○ Yes ○ No	Hay Fever	○ Yes ○ No	Nervousness	○ Yes ○ No	____________	
Chemotherapy/Radiation	○ Yes ○ No	Heart Attack/Disease	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No	____________	
Chronic Cough	○ Yes ○ No	Heart Failure	○ Yes ○ No	Rheumatism	○ Yes ○ No	____________	

ARE YOU ALLERGIC OR SENSITIVE TO ANY OF THE FOLLOWING?

○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic
○ Metal ○ Latex ○ Local Anesthetics
○ Other (please explain): ____________

FOR WOMEN ONLY

Are you pregnant? ○ Yes ○ No
If yes, what is your due date? ____________
Are you nursing? ○ Yes ○ No
Are you taking birth control pills? ○ Yes ○ No

I understand the above information is necessary to provide me with dental care in a a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Signed: ____________ Date: ____________

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