Mission Hills
DENTAL CARE

Dental Registration and History

Dr. Parviz Kohanoff
11550 Indian Hills Road,
Mission Hills, CA, 91345
(818) 361-8777

1. PATIENT INFORMATION

Patient Name ______________________________
Last Name First Name Middle Initial

Date ______________ Birthday ______________

SS# or Insurance ID# ______________ Sex ❑ M ❑ F

Address ______________________________

City ______________ State ________ Zip ________

Home Tel ______________ Work Tel ______________

Mobile # ______________ Occupation ______________

Email ______________ Marital Status ________

Referral Source ______________________________

Notes ______________________________

2. EMPLOYER / SCHOOL

Employer/ School Name ______________________________

Address ______________________________

City ______________ State ________ Zip ________

Phone ______________ Email ______________

Notes ______________________________

3. EMERGENCY CONTACT

Emergency Contact Name ______________________________

Address ______________________________

City ______________ State ________ Zip ________

Phone ______________ Relationship ______________

4. INSURANCE INFORMATION

Responsible Party Name ______________________________

Relationship to Patient ______________________________

Insurance Company ______________________________

Subscriber Name ______________________________

Group # ______________ SS# ______________

Birthday ______________ Other Coverage ❑ Yes ❑ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

____

and assigned directly to Dr. ______________________ 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 in 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 to completed or one year from the date signed below.

Signature ______________________ Date ______________

5. DENTAL HISTORY

Reason for today's visit ______________________________

Former Dentist ______________ Tel ______________ Last X-Ray Date ______________

Last Cleaning ______________ Last Dental Visit ______________

Do you feel pain ❑ Yes ❑ No if yes please describe ______________________________

Do you feel numbness, swelling, or any other sensitivity? ❑ Yes ❑ No if yes please explain ______________________________

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Additional comments about your past dental history ______________________________

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Patient Health Record & Physical Evaluation

6. Please be accurate. It will help us provide you a safe and comprehensive dental treatment.

- ❑ Yes ❑ No Are you having pain or discomfort at this time?
- ❑ Yes ❑ No Do you feel very nervous about having dental treatment?
- ❑ Yes ❑ No Have you ever had a bad experience in a dental office?
- ❑ Yes ❑ No Have you been a patient in a hospital during the past two years?
- ❑ Yes ❑ No Have you been under the care of medical doctor during the past two years?
- ❑ Yes ❑ No Have you taken any medication or drugs during the past two years?
- ❑ Yes ❑ No Have you ever had any excessive bleeding requiring special treatment?
- ❑ Yes ❑ No Has your medical doctor ever said you have cancer or a tumor?
- ❑ Yes ❑ No Have you lost or gained more than 10 pounds in the past year?
- ❑ Yes ❑ No Have you ever taken Fosamax (Bisphosponate), Zometa, Actonel, Boniva, or Aredia?
- ❑ Yes ❑ No Are you on a special diet?
- ❑ Yes ❑ No Do you ever wake up from sleep due to shortness of breath?
- ❑ Yes ❑ No When you walk upstairs or take a walk do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired?
- ❑ Yes ❑ No Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes,) or made sick by Penicillin, Aspirin, Codeine, Vicodin, Latex, or any drug or medicine?

7. Do you have or have you had any of the following? Indicate with (X)

- ❑ Yes ❑ No Heart Failure
- ❑ Yes ❑ No Heart Disease or Attack
- ❑ Yes ❑ No Angina Pectoris
- ❑ Yes ❑ No High Blood Pressure
- ❑ Yes ❑ No Rheumatic Fever
- ❑ Yes ❑ No Artificial Heart Valve
- ❑ Yes ❑ No Heart Pacemaker
- ❑ Yes ❑ No Heart Surgery
- ❑ Yes ❑ No Artificial Joints
- ❑ Yes ❑ No Anemia
- ❑ Yes ❑ No Stroke
- ❑ Yes ❑ No Kidney Trouble
- ❑ Yes ❑ No Ulcers
- ❑ Yes ❑ No Glaucoma
- ❑ Yes ❑ No Pain in Jaw Joint
- ❑ Yes ❑ No Emphysema
- ❑ Yes ❑ No Chronic Bronchitis
- ❑ Yes ❑ No Asthma
- ❑ Yes ❑ No Heart Murmur
- ❑ Yes ❑ No Tuberculosis
- ❑ Yes ❑ No Sinus Trouble
- ❑ Yes ❑ No Hay Fever or Allergies
- ❑ Yes ❑ No Diabetes
- ❑ Yes ❑ No Thyroid Disease
- ❑ Yes ❑ No X-Ray or Cobalt Treatment
- ❑ Yes ❑ No Chemotherapy (Cancer, Leukemia)
- ❑ Yes ❑ No Arthritis
- ❑ Yes ❑ No Rheumatism
- ❑ Yes ❑ No Cortisone Medicine
- ❑ Yes ❑ No Allergy to Latex
- ❑ Yes ❑ No AIDS
- ❑ Yes ❑ No HIV+
- ❑ Yes ❑ No Yellow Jaundice
- ❑ Yes ❑ No Hepatitis A
- ❑ Yes ❑ No Hepatitis B
- ❑ Yes ❑ No Drug or Alcohol Abuse
- ❑ Yes ❑ No Hemophilia
- ❑ Yes ❑ No Venereal Disease
- ❑ Yes ❑ No Cold Sore
- ❑ Yes ❑ No Epilepsy or Seizures
- ❑ Yes ❑ No Fainting or Dizzy Spells
- ❑ Yes ❑ No Nervousness
- ❑ Yes ❑ No Psycchiatric Treatment
- ❑ Yes ❑ No Sickle Cell Disease
- ❑ Yes ❑ No Bruise Easily

Do you have any disease, condition or problem not listed? ______________________________

Name of your medical doctor: ______________________________ Phone #: ______________________________

Are you pregnant? ❑ Yes ❑ No Do you anticipate becoming pregnant? ❑ Yes ❑ No Are you praciticing birth control? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

To the best of my knowledge, all of the preceding answers are true and correct. If i ever have any change in my health, or my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Patient Name: ______________________________ Signature: ______________________________ Date: ______________

Physical Evaluation Results

ASA: I II III IV

BP: ____________

Pulse: ____________

Resp: ____________

Temp: ____________

Medical History Updates

____
Doctor Signature

____
Assistant Signature

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