Patient Information / Medical History:

palo alto Smiles by R. Rastakhiz, DDS

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Sex: M / F Birth Date: ___ /___ /_____ SS#: _____ - ____- _____

Home Address: _____ City: _____ State: ___ Zip: _____

Cell #: _____ Home #: _____ Work #: _____

email: _____ Employer/School: _____

Family Status: ☐Single ☐Married ☐Divorced ☐Child Guardian or Spouse's Name: _____

Primary Dental Insurance: ☐None ☐Delta ☐Metlife ☐Cigna ☐Aetna ☐Other: _____

Group #: _____ ID #: _____

Subscriber's Relationship to Patient: ☐ Self ☐Spouse ☐Parent ☐Other

Subscriber's Name (If not the Patient): _____ Birth Date ___ /___ /____

Secondary Dental Insurance: ☐None ☐Delta ☐Metlife ☐Cigna ☐Aetna ☐Other: _____

Group #: _____ ID #: _____

Subscriber's Relationship to Patient: ☐ Self ☐Spouse ☐Parent ☐Other

Subscriber's Name (If not the Patient): _____ Birth Date ___ /___ /____

- Are you Pregnant?	Yes No N/A	- Require Antibiotics Premedication before dental visits?	Yes No
- Taking Blood Thinners?	Yes No	- Ever used Bisphosphonates/Fen-Phen/Fosamax/Bovita?	Yes No
- Any Allergies: _____	Yes No	- Ever had any complication during a dental visit? _____	Yes No

Have you EVER had any of the following?

Heart Problem	Yes No	Stroke	Yesnbb No	Cancer	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Chemotherapy	Yes No
Artificial Heart Valve	Yes No	Fainting/Dizziness	Yes No	Radiation Therapy	Yes No
Endocarditis	Yes No	Neurological Disorder	Yes No	Steroid Treatment	Yes No
Pace Maker	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Defibrillator	Yes No	Drug Addiction	Yes No	Asthma/COPD	Yes No
High Blood Pressure	Yes No	Alcoholism	Yes No	Smoking	Yes No
Ulcers	Yes No	Kidney Disease	Yes No	Diabetes	Yes No
Artificial Joints	Yes No	Liver Disease	Yes No	Thyroid Disease	Yes No
Arthritis	Yes No	Hepatitis A/B/C	Yes No	Blood Disorder	Yes No

Any Medical Condition(s) Not Mentioned Above? _____

List of current medications: _____

Pharmacy (name/address/phone): _____

Dental concerns at this time:

Tooth Pain	Yes No	TMD/TMJ pain	Yes No	Grinding/Clenching	Yes No
Bleeding Gums	Yes No	Locking Jaw	Yes No	Dry Mouth	Yes No
Bad Breath	Yes No	Swelling	Yes No	Food Catching	Yes No
Sensitive Teeth	Yes No	Any other dental concern: _____			

I would like my teeth to be: ☐Whiter ☐Straighter

CONSENT FOR SERVICES / ASSIGNMENT AND RELEASE I, the undersigned, certify that I (or my dependent) have the above insurance coverage and assign directly to R Rastakhiz DDS, Inc 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 hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I consent to the diagnostic procedures, including x-ray procedures and photographs, and treatment by the dentist necessary for proper dental care.

Signature: X _____ Relationship to Patient_____ **Date**: ___ /___ /___