Izadi & Szeto
APDC
Practice Limited to Microscopic & Surgical Endodontics
22982 El Toro Rd, Ste# 100, Lake Forest, CA 92630

DENTAL REGISTRATION & HISTORY

1. *PATIENT INFORMATION*

Patient_____ S.S.# _____
Address_____ Date of Birth_____
_____ Sex: Male Female Age_____
Driver's License_____ Marital Status_____

Occupation_____ Employer_____
Employer's Address_____ Employer's Phone_____

If patient is minor, who is responsible for this account?
Name_____ S.S.#_____ Driver's License_____
Address_____

2. *DENTAL INSURANCE*

Is Patient covered by insurance? Yes No
Subscriber's Name_____ S.S.#_____
Date of Birth_____ Relationship to Patient_____
Insurance Company_____ Group #_____
Is Patient covered by additional insurance? Yes No
Subscriber's Name_____ S.S.#_____
Date of Birth_____ Relationship to Patient_____
Insurance Company_____ Group #_____

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Izadi & Szeto, A.P.D.C. 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____ Date_____
Relationship to Patient_____

3. *PHONE NUMBERS*

Home_____ Work_____ Alternate Number_____
Best time & place to reach you_____

IN CASE OF EMERGENCY, CONTACT (specify someone who does not live in your household):
Name_____ Relationship_____
Home Phone_____ Work Phone_____

4. *REFERRING DENTIST*

Referring Dentist_____ Phone_____
Address_____

5. *HEALTH HISTORY*

Physician's Name_____ Date of last visit_____

1. Have you been a patient in our office in the past? ----------Yes No
2. Are you in good health now? ----------Yes No
3. Have you been under the care of a physician in the past two years? ---------Yes No
4. Have you been a patient in a hospital during the past two years? ----------Yes No
5. Have you ever had any excessive bleeding requiring special treatment? ---Yes No
6. Have you had any other serious illnesses? ----------Yes No
7. (Women) Are you pregnant now? ----------Yes No
8. Date of last dental treatment? _____
9. Are you currently taking Bisphosphonates (Fosamax, Boniva, Zometa)?----Yes No
10. Are you currently undergoing Chemotherapy----------Yes No

Do you have any of the following medical conditions:

Heart Trouble---------- Yes No
Ulcers---------- Yes No
Hepatitis---------- Yes No
Stroke---------- Yes No
Arthritis---------- Yes No
Artificial Joint---------- Yes No
High Blood Pressure--------- Yes No
Tuberculosis---------- Yes No
Pacemaker---------- Yes No
Venereal Disease---------- Yes No
Tumor or Cancer---------- Yes No
Rheumatic Fever---------- Yes No
Phen Phen----------Yes No

Diabetes---------- Yes No
Artificial Heart Valve---------- Yes No
Asthma---------- Yes No
Sinus Trouble----------Yes No
Psychiatric Treatment---------- Yes No
Anemia---------- Yes No
Congenital Heart Lesions------ Yes No
Jaundice----------Yes No
Cough---------- Yes No
Epilepsy----------Yes No
Heart Murmur---------- Yes No
HIV/AIDS----------Yes No
Others not listed:_____

ALLERGIES

Aspirin---------- Yes No
Barbiturates(sleeping pills)--Yes No
Iodine----------Yes No
Sulfa----------Yes No
Others:_____

Penicillin----------Yes No
Codeine---------- Yes No
Latex---------- Yes No
Local anesthetics---------- Yes No

MEDICATIONS

List all medications you are currently taking:

_____

_____

Patient Signature (guardian if minor)_____ **Date**_____

6. *UPDATES (to be filled in at future appointments):*

Has there been any change in your health since your last dental appointment?
For what conditions?_____
List new medications_____
Patient Signature_____ **Date**_____
Doctor Signature_____ **Date**_____