Izadi & Szeto, A.D.C.
Practice Limited to Microscopic & Surgical Endodontics

Dental Registration and Health History

PATIENT INFORMATION

Name: _____ S.S.# _____
Address _____ Date of Birth _____
City _____ State: _____ Sex: ( )Male ( ) Female Age: ____
Zip Code: _____ Marital status _____
E-mail Address _____ Driver's License _____
Occupation _____ Employer _____
Employer's Address _____ Employer's Phone _____

If patient is a minor, who is responsible for this account?

Name _____ S.S. # _____
Driver's License _____ Address _____

Pharmacy Name and Address _____
Pharmacy Phone Number _____

DENTAL INSURANCE

Is Patient covered by Dental insurance? Yes No
Subscriber's Name _____ S.S. # _____
Date of Birth _____ Relationship to patient _____
Insurance Company _____ Group # _____
Is Patient covered by Secondary Dental 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.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 _____

PHONE NUMBERS

Home _____ Work _____ Cell _____

EMERGENCY CONTACT

Name _____ Relationship _____
Home/Cell 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**_____