Babak Noohi, DDS, MS
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Patient Information

Complete Name: _____ Preferred Nickname: _____

Date of Birth: _____ If under age 18, Name of Legal Guardian _____

Employer: _____ Type of work/profession _____

Gender: ☐ Female ☐ Male Marital Status: _____

Address: _____ City:_____ State: _____ Zip Code: _____

Telephone Numbers: Home: _____ Work: _____ Cell: _____

E-Mail address: _____ Preferred communication method: _____

Who may we thank for referring you? _____ ☐ Dr. ☐ Family ☐ Friend ☐ Co-Worker
Please list any family members that are also our patients: _____

Health Information

Have you ever had any of the following? Please check all that apply.

☐ Allergies _____	☐ Blood Disease	☐ Hepatitis	☐ Respiratory Problem
☐ Allergies Aspirin	☐ Cancer, Yr :_____	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Allergies Codeine	☐ Diabetes	☐ HIV	☐ Rheumatism
☐ Allergies Erythro	☐ Dizziness	☐ Jaundice	☐ Sinus Problems
☐ Allergies Hay Fever	☐ Epilepsy	☐ Kidney Disease	☐ Stomach Problems
☐ Allergies Latex	☐ Excessive Bleeding	☐ Liver Disease	☐ Stroke
☐ Allergies Penicillin	☐ Fainting	☐ Mental Disorders	☐ Tuberculosis
☐ Allergies Sulfa	☐ Glaucoma	☐ Nervous Disorders	☐ Tumors
☐ Anemia	☐ Growths	☐ Pacemaker	☐ Ulcers
☐ Arthritis	☐ Head Injuries	☐ Pregnancy ____	☐ Venereal Disease
☐ Artificial Joints, Yr:_____	☐ Heart Disease	Due:_____	☐ Other (please list)
☐ Asthma	☐ Heart Murmur	☐ Radiation Treatment	_____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, explain: _____

Are you now under the care of a physician? ☐ Yes ☐ No If yes, explain: _____
Name of physician: _____ Telephone: _____

Do you have any problems that need further clarification: ☐ Yes ☐ No
If yes, explain: _____

Please list any medications you are currently taking: _____
Do you take blood thinning medications? ☐ Yes ☐ No, If yes, which one? _____

Do you smoke? ☐ Yes ☐ No If yes, number of cigarettes/day: _____ Number of cigars/day: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, number of drinks/day: _____ Number of drinks/week: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health or health conditions, I will inform the doctor(s) before or during my next appointment.

_____ _____
Signature of Patient or Legal Guardian **Date**

Dental History

Patient Name: _____ Date: _____

Reason for today's visit: _____

Date of last dental visit: _____ Date of Last Dental X-ray(s)_____

Please indicate if you have any of the following symptoms and/or habits:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Blisters on lips or mouth
- ☐ Burning Sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette, pipe or cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Headaches
- ☐ Jaw pain or tiredness
- ☐ Latex allergy
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Missing teeth
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment, when: _____
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold or heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth
- ☐ Stained or darkened teeth
- ☐ Worn or chipped teeth
- ☐ Other _____

Do you typically pre-medicate with an antibiotic prior to dental treatment? ☐ Yes ☐ No, If yes, with what?_____

Do you floss? _____ How Often? _____

How often do you brush? _____ ☐ Manual toothbrush ☐ Electric toothbrush

Are you happy with your smile? ☐ Yes ☐ No
If no, please describe what you do not like about your smile?

_____

_____

Office Policies – Please read policies and sign below

Appointments: Appointment times are reserved for you. We make every effort to reach you to remind you of your appointment. If you are unable to keep an appointment, we do require a 24-hour notice prior to canceling an appointment.

Payments: As a condition of your treatment by our office, payment is due in full at the time services are rendered. We are a 'fee for service' office and therefore require payment from patients for their care. You, or your legal guardian, are fully responsible for all fees charged regardless of any dental insurance coverage.

Treatment Plan Estimates: Fee estimates are based on the proposed treatment plan. We will make every attempt to plan accurately, but unanticipated situations or changes do arise and can affect treatment costs. Patients will be notified of applicable fees before services are rendered. A fee estimate is effective for 90 days.

Health Insurance Portability and Accountability ACT (HIPAA)
I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices.

Permission to Use Facial Images
I do _____ or do not _____ agree to have visual images of my face, made in connection with my dental examination or treatment used for educational purposes. The visual images WILL NOT have your name attached to them.

_____ _____
Signature of Patient or Legal Guardian **Date**

Patient Registration Form
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Patient Name: _____ Date: _____

Emergency Contact Information

_____ _____
Full Name of Emergency Contact (Please print) Relationship to Patient

_____ _____
Telephone Number Cell Phone

I give Dr. Noohi permission to discuss my treatment and/or financial arrangements with your emergency contact person.

_____ _____
Signature of Patient or Legal Guardian **Date**

Dental Insurance Policies

(Please complete this section " **only if"** **patient carries dental insurance)**

Patients who carry dental insurance are responsible for full payment at the time services are rendered. We are not a participating provider on any insurance plan. As a courtesy, our office will prepare and file insurance claims and requests for pre-treatment estimates for insurance benefits. However, it is the sole responsibility of the patient to verify insurance coverage and benefits with their insurance carrier.

I have read and understand this policy. _____ _____
Patient Signature **Date**

Primary Insurance:

Name of Policy Holder: _____ Date of Birth of Policy Holder: _____

Patient relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Employer of Policy Holder:_____

Insurance Carrier Name: _____ Telephone Number: _____

Address: _____

City _____ State: _____ Zip Code: _____

Electronic Payor Number for Insurance Carrier for electronic filing purposes: _____

Policy Holder's Member Identification Number (ID) or Social Security Number: _____

Group Name: _____ Group Number: _____

Responsible Party Information

(Please complete this section " **only if"** **different from the patient information)**

Responsible Party Name: _____Relationship to patient: _____

Social Security Number: _____ Driver's License Number: _____State:_____

Date of Birth:_____ Gender: ☐ Female ☐ Male

Telephone Home: _____ Work: _____ Cell: _____

Address: _____City: _____ State: ____ Zip Code: _____

Employer Name: _____

As the responsible party, you agree to pay in full at the time the services are rendered to the patient.

_____ _____
Signature of Responsible Party or Legal Guardian **Date**