Dr. Babak Noohi, DDS, MS
P R O S T H O D O N T I S T

Patient Registration

Patient Name: _____

first name **last name** **Middle Initial** **Preferred Name**

Sex: **Marital Status:** _____ **Birth Date:** _____/_____/_____ **Social Security** _____-_____-_____

Address: _____ **State:** _____ **Zip Code:** _____

Home# _____ **Wk#** _____ **Cell#** _____

Email Address: _____ **Please tell us what is the best way to reach you: Cell Email Work Home**

In case of an emergency, who should be notified? Name: _____ **Phone:** _____

Whom may we thank for referring you? _____

Dental Insurance name: _____ **Member Id#** _____ **Group #** _____

Dental History

What is the main reason for this visit? _____ **Are you having any dental pain?**

When was your last dental exam and cleaning? _____ **Please tell us the name of you previous Dentist.** _____

Did you have Orthodontic treatment? Yes No **Do you have your Orthodontic Retainers? Yes No**

Are you interested in Dental Whitening? Yes No **Are you interested in Cosmetic Dentistry? Yes No**

Have you ever experienced Dental Anxiety during a dental procedure? Yes No

Please let Dr. Noohi, know if you would like Nitrous Oxide or any anti-anxiety medications prior to your dental treatments. Yes No

Do you have any dental concerns or questions at this time? _____

Have you ever been treated for periodontal disease? **Have you ever been treated for TMJ disorders?**

Have you had your 3rd molars (wisdom teeth) extracted? **Have you had other teeth extracted?**

If answered "Yes" why? _____ **Are you interested in replacing the missing teeth?**

Medical History

Physician's Name and phone#_____

Have you ever had the following Conditions? (Check ALL categories that apply and put a date of diagnosis)

____Heart Problems
____Mitral Valve Prolapse
____Artificial Heart Valve
____High Blood Pressure
____History of Stroke
____Low Blood Pressure
____Blood Disorders
____Anemia
____Hemophilia
____ADHD
____Nervous Disorders
____Depression
____Anxiety
____Arthritis
____Artificial Joints (Hip, Knee, Shoulder)
____Epilepsy
____Kidney Disorders
____Sinus / Nose Surgery
____Trauma / Fracture of face
____Celiac Disease
____Ulcer
____Allergy to Anesthetics
____Blood Thinner medications
____Daily Baby aspirin
____HIV +
____ Allergy to Medicine
____Allergy to Latex
____Allergy to Iodine
____History of Faint
____Lung Disease
____Chemical Dependency
____ Alcoholism
____ Migraine Headaches
____Rheumatic Fever
____ Immunosuppressive Disorder
____Lupus
____ Transplant Organ:
____ Jaundice
____ Liver Disease
____ Hepatitis: Type_____ Year_____
____Diabetes: Type_____ Year_____
____Cancer: Site _____ Year_____
____Radiation Treatment:
which area? _____

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Do you have any allergies or adverse reactions to any medications that you know of?
_____

Do you have to pre-medicate for any dental procedures? **If yes, say Why?** _____
_____

Are you smoking cigarettes? **How many cigarettes a day?** _____ **How many years?** _____

Please List all the medications you are taking, include dose and frequency:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Are you currently under the care of a physician? **Why?** _____

_____

For FEMALE patients: please answer if applicable.

Do you suspect that you are pregnant? _ **How far along are you?** _____**Are you nursing?** _____

Is there anything else we should know about your medical history?

** We value our patients and it is equally important to value the doctors time. For cancelling or rescheduling an appointment we ask that patients give at least 24 hrs advance notice during the business hours (not during weekends nor holidays or after hours). Please note that it is our office policy to charge a $75 failed appointment fee (no call no show) and consistent failed appointments may result in termination from the practice. **

This information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance benefits for which I am entitled. I will not hold my dentist and / or staff members responsible for any errors or omissions that may have been made in completion of this form.

I consent to all necessary dental diagnostic procedures, including, but not limited to x-rays, exams, photographs, and diagnostic test.

Patient's **Signature:** _____ **Date:** _____