WELCOME TO OUR OFFICE

ROBERT SALEHRABI, D.D.S

Advanced Microscopic Endodontics

Date: _____

Patient's Name: _____ **Nickname:** _____

Date Of Birth: _____ **Social Security #:** _____

Name Of Spouse: _____ **Spouse Social Security#:** _____

If A Child, Parent's Name: _____

Residence Address: _____ **Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Telephone Residence: (___) _____ **Business: (___)** _____ **Mobile: (___)** _____

E-Mail Address: _____ **Fax: (___)** _____

Employed By: _____ **Position:** _____

Business Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse Employed By: _____ **Business Telephone:** _____

Whom May We Thank For Referring You? _____

Nearest Relative Not Living With You: _____ **Telephone:** _____

Contact In Case Of Emergency: _____

Person Responsible For Payment Of Account: _____

(Name, Address, Telephone If Different Than Above)

DENTAL INSURANCE

Primary Dental Insurance

Your Dental Insurance Is Through (Check One)

- ☐ **Your Employer**
- ☐ **Your Spouse's Employer**
- ☐ **Other**

Employee's Full Name: _____

Employee's Date Of Birth: _____

Employee's Social Security: _____

Employer's Name: _____

Employer's Address: _____

Insurance Name: _____

Insurance Address: _____

Policy #: _____ **Group #:** _____

Employer ID#: _____ **Employer ID#:** _____

Insurance Co. Telephone: (___) _____

Secondary Dental Insurance (If You Have Dual Coverage)

Your Secondary Dental Insurance Is Through (Check One)

- ☐ **Your Employer**
- ☐ **Your Spouse's Employer**
- ☐ **Other**

Employee's Full Name: _____

Employee's Date Of Birth: _____

Employee's Social Security: _____

Employer's Name: _____

Employer's Address: _____

Insurance Name: _____

Insurance Address: _____

Policy #: _____ **Group #:** _____

Employer ID#: _____ **Employer ID#:** _____

Insurance Co. Telephone: (___) _____

FOR OFFICE USE ONLY

Annual Max: _____ **Per:** _____ **Calendar Year:** ☐ **Or Fiscal Year:** ☐

Benefit Used This Year: _____ **Benefit Remaining:** _____

Endo Is Paid At: _____**%**_____ **Of UCR:** ☐ **Or Fee Schedule:** ☐

If Fee Schedule: For Procedure ADA Code: _____ **The Fee Is:** _____

Submit Claims To: _____ **Name Of The Rep. Giving Info:** _____

Please Circle "Yes" If You Have Ever Had The Fo1lowing. If You Are Not Sure, Do Not Answer The Question

Heart/Blood Vessels

Rheumatic Fever	Y N
Rheumatic Heart Disease	Y N
Heart Valve Damage	Y N
Heart Murmur	Y N
Congenital Heart Defect	Y N
Artificial Heart Valve	Y N
Prolapsed Heart Valve	Y N
High Blood Pressure	Y N
Heart Attack (DATE)	Y N
Stroke (DATE)	Y N
Heart Surgery (DATE)	Y N
Vascular Surgery (DATE)	Y N
Pacemaker	Y N
Coronary Heart Failure	Y N
Congestive Heart Failure	Y N
Angina Pectoris/Chest Pain	Y N
Irregular/Rapid Heart Beats	Y N
Other Heart Or Vessel Disorder	Y N
Blood Clots Thrombosis	Y N
Anemia	Y N
Sickle Cell Disease/Trait	Y N

Blood

Hemophilia	Y N
Transfusion (DATE)	Y N
Bruise Easily For No Apparent Reason _____	Y N
Leukemia/ Multiple Myeloma	Y N
Nervous System	Y N
Epilepsy	Y N
Seizure Disorder	Y N
Multiple Sclerosis	Y N
Trigeminal Neuralgia	Y N
Chronic Pain	Y N
Anxiety/Depression	Y N
Alzheimer's Disease/Dementia	Y N
Psychiatric Treatment	Y N
Psychological Counseling	Y N
Persistent Dizziness/Fainting Spells _____	Y N
Persistent Numbness/Tingling	Y N
Other Nervous System/Mental Disorder _____	Y N

Head and Neck

Glaucoma	Y N
Chronic Sinusitis	Y N
Injury To Head, Neck, Jaw Or Teeth	Y N
Headaches	Y N
Unexplained Visual Change	Y N
Frequent Or Severe Nosebleeds	Y N
Persistent Sore Throat Or Hoarseness	Y N
Recurrent Neck ache Or Neck Pain	Y N
Recent Difficulty Swallowing	Y N
Other Head Or Neck Disorder	Y N

Endocrine

Diabetes	Y N
Thyroid Problem	Y N
Other Thyroid Condition	Y N
Cushing's Syndrome	Y N
Parathyroid Condition	Y N
Other Endocrine Condition	Y N

Musculoskeletal/Connective Tissue

Sjogren's Syndrome (DATE)	Y N
Arthritis	Y N
Artificial Joint	Y N
Fibromyalgia / Rheumatism	Y N
Pagets Disease	Y N
Osteoporosis	Y N
Respiratory	Y N
Tuberculosis (TB)	Y N
Asthma	Y N
Chronic Bronchitis	Y N
Emphysema	Y N
Persistent Cough	Y N
Cough Up Bloody Sputum	Y N
Shortness Of Breath	Y N
Other Respiratory Disorder	Y N

Urinary Tract

Kidney Disease	Y N
Renal Dialysis	Y N
Venereal Disease	Y N
Sexually Transmitted Disease	Y N
Other Urinary Disorder	Y N

Digestive System

Hepatitis	Y N
Cirrhosis Of The Liver/Liver Disease	Y N
Ulcers	Y N
Jaundice	Y N
Frequent Heartburn Or Reflux	Y N
Frequent Nausea/Vomiting	Y N
Other Digestive Disorder	Y N

Cancer History

Cancer If Yes, What Type _____	Y N
Leukemia	Y N
Benign Tumors/Growths	Y N
Surgery Type Of Treatment_____	Y N
Radiation Therapy	Y N
Chemotherapy	Y N
Hormone Therapy	Y N

Allergy History

Are You Allergic To Or Have You Ever Had A Bad Reaction To Any Of The Following?

Dental Anesthetics	Y N
Penicillin	Y N
Sulfa Drugs	Y N
Other Antibiotics	Y N
Aspirin	Y N
Latex Products	Y N
Metals Including Jewelry	Y N
Other Allergy	Y N

Family History

Has Anyone In Your Family (Grandparent, Parent, Sibling, Child) Ever Had The Following?

Diabetes	Y N
Heart Disease	Y N
Depression Or Anxiety	Y N
Tuberculosis	Y N
Any Other Disorder That "Runs In Your Family _____	Y N

Please Circle "Yes" If You Have Ever Had The Fo1lowing. If You Are Not Sure, Do Not Answer The Question

Miscellaneous

Lupus Crythematosis Y N
Organ Transplant Y N
If Yes, Which Organ?
_____
Suppressed Immune System Y N
Persistent Fever Y N
Taken Steroid / Prednisone Y N
Tested Positive For *HIV* Y N
Been Diagnosed With AIDS Y N
Taken Prescription Diet Pills Y N
If Yes, Please Check Type
_____
Pondimin 0 PhenFen Y N
Redux 0 Other Y N

Miscellaneous (Continued)

Used Tobacco Products? Y N
If Yes, What Type?
_____
How Much?_____ How Long?_____
Still Using Tobacco? Y N
Would You Like To Quit? Y N
Quit On? (DATE)
Drink Alcoholic Beverages? Y N
If Yes, How Much? _____
Used Methamphetamine, Amphetamines, Or "Speed"? Y N
Used Intravenous Drugs? Y N
Used Cocaine Or "Crack"? Y N

Miscellaneous (Continued)

Used Any Other Recreational Drug? Y N
Are You A Recovering Alcoholic Or Addict? Y N

Women Only

Are You Pregnant Or Is There A Possibility That You May Be Pregnant? Y N
If Yes, Due Date _____
Are You Breast Feeding Y N
Are You In Or Have You Passed Through Menopause (Change Of Life)? Y N

Do You Have Any Other Condition That You Think We Should Know About? ☐ **Yes** ☐ **No**

_____

Please Circle All Of The Medications You Are Taking:

Heart	Blood Thinners	Hormones	Antibiotics	Tranquilizers
Nitroglycerin	Blood Pressure	Insulin/Diabetic Drugs	Antihistamine	Antidepressants
Digitalis	Oral Contraceptive	Thyroid	Cyclosporin A	Pain
Aspirin (Tabs/Day)	Steroids/Cortisone	Nifedipine		

Please List All Medication Names And Dosages (Include Over-The-Counter, Herbal And Nutritional Supplements), That You Are Currently Taking:

_____

_____

_____

_____

Signature Of Patient, Parent Or Guardian:

_____

Date:

Signature Of Reviewing Provider:

_____

Date: