Montgomery Street Dental - 4/20/2022

Demographic Information

Patient Information

Prefix	How do you identify?	If additional gender category, please specify	Middle Name
Nickname	What are your preferred pronouns?	If other, please specify:	Birth Date
Age	Social Security Number	Email Address	Mailing Address
Apt.	City	State	Zip
Home Phone	Mobile Phone	Have you ever been a patient of our practice?	Has a family member ever been a patient of our practice?
Your Dentist Name	Your Medical Doctor Name	How did you find our practice?	Who were you referred by?

Section Two

Drivers License Number		
Nearest relative not living with you		
First Name	Last Name	Phone Number
Employer / Business		
Employer Name	Business Phone	Personal Payment Type

Insurance Information

General Insurance Information

Employed	Do you belong to a PPO or HMO?	Marital status
Who will be responsible for your account?		

Father	Mother	Self	Spouse
Other	Other Description	First Name	Last Name
Social Security Number			
Responsible party birth date / Age			
Birth Date		Age	
Responsible party phone / Drivers license			
Home Phone		Drivers Llicense Number	
Address			
Street	Apt.	City	State
Zip (Postal Code)			
Employer / Business			
Employer Name	Business Phone	Are you a student?	

Spouse or other guarantor information (if different from above)

Is the information different from the above?		
Spouse or other guarantor		
First Name	Last Name	Relation
Birth Date / Social Security Number		
Birth Date	Social Security Number	
Address		

Street	Apt.	City	State
Zip (Postal Code)			

Employer / Business		
Employer Name	Home Phone	Business Phone

Primary Insurance Information

Do you have Primary Insurance?

Insurance Type:	Employer / Business	Business Address	City
State	Zip	Business Phone Number	Plan Name
Insurance Company Name	Policy I.D. Number	Insurance Company Address	City
State	Zip	Insurance Company Phone	Group Number
Group Name			
Insured Party			
First Name	Last Name	Relation to Patient	Birth Date
Insured Party Sex	Insured Party Address	City	State
Zip			

Secondary Insurance Information

Do you have Secondary Insurance?

Insurance Type:	Employer / Business	Business Address	City
State	Zip	Business Phone Number	Plan Name
Insurance Company Name	Policy I.D. Number	Insurance Company Address	City
State	Zip	Insurance Company Phone	Group Number
Group Name			
Insured Party			
First Name	Last Name	Relation to Patient	Birth Date
Insured Party Sex	Insured Party Address	City	State
Zip			

Dental Information

Dental Information

Reason for today's visit	Are you in pain?

Dental Information Part 2

Please indicate any of the following problems by clicking "yes" on the corresponding question

Discomfort, clicking, or popping in jaw	Red, swollen, or bleeding gums	A removable dental appliance	Blisters / sores in or around the mouth
Prolonged bleeding from an injury / extraction	Recent infections or sore throat	My teeth are sensitive to hot	My teeth are sensitive to cold
My teeth are sensitive to sweets	My teeth are sensitive to biting	Stained teeth	Locking jaw
Bad breath	Toothache	Burning tongue / lips	Lost / broken filling(s)
Teeth grinding / clenching	Ringing in ears	Broken / chipped tooth	Gum disease
Difficulty closing jaw	Difficulty opening jaw	Loose / shifting teeth	Food caught between teeth
Swelling / lumps in mouth	Other	Last dental exam	Last dental x-rays
Times a day you brush?	Times a week you floss?	How would you rate your smile? (worst to best)	Would you like whiter teeth?
What type of toothbrush bristles do you use?			

Medical History

Medical History

Are you in good health?	What is your height?	What is your weight?	Are you under the care of a physician?
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	Have you had any illness, operation or been hospitalized in the past five years?	Have you ever had general anesthesia?	Have you, or a family member, had any unusual or serious reactions to general anesthesia?

Have you had or do you currently have...

High blood pressure	Low blood pressure	Mitral valve prolapse	Rheumatic fever
Heart murmur	Chest pain/angina	Heart attack(s)	Irregular heart beat
Cardiac pacemaker	Heart surgery	Damaged heart valves	Pneumonia, Bronchitis or Chronic Cough
Chronic fatigue / night sweats	Trouble climbing 1-2 flights of stairs	Anemia	Asthma
Bleeding Tendency	Blood transfusion	Blood Disorder	Bruise easily
Eye disease / glaucoma	Contact lenses	Jaundice / Liver disease	Hepatitis
Gallbladder trouble	Fainting spells	Convulsions / epilepsy	Stroke
Thyroid trouble	Diabetes	Low blood sugar	Are you on dialysis?
Kidney trouble	Mental health problems	Problems with immune system (possibly from med. / surg.)	Delay in healing
Hay fever / Sinus problems	Snoring	Sleep Apnea / CPAP	Respiratory problems
Tuberculosis	Emphysema	Do you smoke?	Do you use chewing tobacco?
A history of drug abuse	A history of alcohol abuse	Abnormal bleeding	Sexually transmitted disease
Contagious diseases	Infectious mononucleosis	Swollen Ankles	Arthritis / Joint disease
Prosthetic implant	Joint replacement	Osteoporosis / osteopenia	Osteonecrosis
Stomach ulcers	Tumor or growth	Cancer / Radiation / Chemotherapy	GI Troubles/IBS/Colitis
Are you on a diet?			

For women only

Note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Is there a possibility of pregnancy?	Are you nursing?	Are you taking birth control pills?

Medications / Allergies

Medications / Allergies

Are you taking any kind of medication, drug, pills?

Are you now taking:

Nerve pills	Diet pills	Pain killers (including aspirin)	Tranquilizers
Muscle relaxers	Insulin	Stimulants	Antidepressants
Blood thinners (Coumadin, Aspirin)	Are you taking, or have you ever taken, any bone density meds. or bisphosphonates, such as Fosamax, Boniva, Actonel, IV Zometa, Reclast, Xgeva, Prolia, or Aredia within the past 12 years.	Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products)	

Are you allergic or had a reaction to:

Penicillin	Sodium pentothal, Valium, or other tranquilizers	Soy	Sulfa Drugs
Aspirin	Eggs/Yolk	Local anesthetic (numbing medication)	Codeine or other narcotics

Sulfites	Amoxicillin	Latex	Do you have any known allergies?
Please list any allergies other than drug allergies:			

Conclusion

In case of emergency

Contact:

Emergency Contact Full Name	Home Phone	Relation to Patient

Verification

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Sign

Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Sign

Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Sign

Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Sign

Date

Consent To Dental Photography

Consent To Dental Photography

I, (Patient) authorize Montgomery Street Dental - Dr. Alireza Khoshvaghti, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.

First Name	Last Name

I consent to allow the photographs to be used for the following:

-Dental Records

-Dental Research

-Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books

-Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Check here if you do not want your full-face shot used for any of the above purposes

Signature (Patient)

Date