

Welcome to Pacific Coast Dental Corporation, office of Dr. Jalil Babagoli.

Please take a few minutes to answer the following questions so we can better assist you with your dental needs.

PATIENT INFORMATION

Today's Date: _____ Birth Date: _____ Patient Social Security #: _____

Patient Name: _____
(Last Name) (First Name) (Initial)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Male Female Single Married Widowed Divorced Separated

Patient Home Phone: _____ Patient Work Phone: _____

Employer: _____ Employer Phone: _____

Employer Address: _____

In Case of Emergency Contact:

Name: _____ Relationship: _____

Emergency Home Phone: _____ Emergency Work Phone: _____

Whom may we thank for referring you to us? _____

PRIMARY INSURANCE

Individual responsible for this account: _____
(Last Name) (First Name) (Initial)

Relationship to Patient: _____ Birth Date: _____ Social Security # _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employed by: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Subscriber ID# _____ Insurance Group # _____

ADDITIONAL INSURANCE

Insured Individual's Name: _____

(Last Name) (First Name) (Initial)

Relationship to Patient: _____ Birth Date: _____ Social Security # _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Insured Party Employed by: _____ Business Phone: _____

Insurance Company: _____

Insurance Company Address: _____

Insurance Subscriber ID# _____ Insurance Group # _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance

Signature: _____ Date: _____

FAMILY HEALTH INFORMATION

Some health conditions are the result of hereditary weaknesses. Information that you can furnish us pertaining to your immediate family members (brothers, sisters, parents, grandparents) will give us a better understanding of your health needs.

RELATIONSHIP TO YOU	FAMILY MEMBER PAST AND PRESENT HEALTH PROBLEM

MEDICATIONS

List all medications/prescriptions that you are currently taking:

Pharmacy _____ Phone _____

ALLERGIES

- Aspirin
- Barbiturates (Sleeping Pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other (Please List) _____
- _____
- _____

CHECK ANY SYMPTOM(S) OR CONDITION(S) THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Arm Pain or Numbness | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Itching | <input type="checkbox"/> Prostate Problem |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rapid Heartbeat |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Earache | <input type="checkbox"/> Lack of Bladder Control | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leg Pain or Numbness | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Feet Pain or Numbness | <input type="checkbox"/> Loss of Hearing | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Scars |
| <input type="checkbox"/> Bowel Changes | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shoulder Pain or Numbness |
| <input type="checkbox"/> Brights Disease | <input type="checkbox"/> Gas | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Measles | <input type="checkbox"/> Sore that won't heal |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hand Pain or Numbness | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Stomach Aches or Pains |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Headache | <input type="checkbox"/> Mumps | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Change in Moles | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nausea | <input type="checkbox"/> Swelling Ankles |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Neck Pain or Numbness | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Hip Pain or Numbness | <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Vision Flashes |
| <input type="checkbox"/> Depression/Nervousness | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hives | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vomiting Blood |

CHECK DEGREE OF HABITS BELOW, ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

	Heavy	Casual	Light	None		Heavy	Casual	Light	None		Heavy	Casual	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar/Sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____