

 | **Michael Mostofi, D.D.S.** | 15 Mareblu Ste 360 Aliso Viejo, CA 92656

**DENTAL OFFICE NEW PATIENT FORM**

Thank you for selecting our dental office.

To help us meet all of your health care needs, please complete this form as accurately as possible. ☺

**I. PATIENT INFORMATION:**Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date \_\_/\_\_\_/\_\_\_\_ Age \_\_\_
Male ( ) Female ( ) Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_
Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Previous Dentist:\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Current Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**II. TELEPHONE & EMAIL:**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­\_\_\_\_\_
*Emergency Contact*:
Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**III. PERSON RESPONSIBLE FOR ACCOUNT:**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**IV. INSURANCE INFORMATION:**

**Primary Insurance:**

Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance Telephone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance:**Subscriber Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_
Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber’s SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Insurance Telephone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V. NOTICES:** Please Initial Below:\_\_\_\_\_ I have read and understood the Dental Materials Fact Sheet\_\_\_\_\_ I have read and understood HIPAA (Notice of Privacy Act)
\_\_\_\_\_ I assign Mostofi Dental Corporation all my right, title, and interest in

 and to any and all dental benefits otherwise payable to me for oral health

 treatment rendered by the assignee. I acknowledge that billing my

 insurance company for the services rendered is a courtesy done by

 MOSTOFI DENTAL CORPORATION. I am still responsible for paying

 the above- referenced dentist to the extent the relevant insurer or payer

 does not pay the dentist in full.
\_\_\_\_\_ I was notified: Payments are expected at the time services are

 rendered. That if I must change my appointment I must notify MOSTOFI

 DENTAL CORPORATION at least 48 hours notice to avoid a $55.00

 fee. \*(Emergencies are an exemption).
\_\_\_\_\_ I am aware that MOSTOFI DENTAL CORPORATION offers

 different payment plan options.

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental series that I may need during diagnosis and treatment with my informed consent.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date



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**DENTAL HISTORY:**Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your current dental health is: Good Fair Poor

***Do you***:
Require antibiotics before dental treatment? Y N

Have pain now? Y N

Now have or experienced pain /discomfort in your jaw joint ? Y N

Clench or grind your teeth while asleep or awake? Y N

Like your smile? Y N

Have bleeding gums? Y N

Have sensitivity in any of your teeth? Y N

You have family history of gum disease or tooth loss? Y N

Have mouth odors? Y N

Do food tend to be caught between your teeth? Y N

How many times a week do you floss?\_\_\_\_\_ a day do you brush? \_\_\_\_\_

***Have you ever had:***

Orthodontic treatment? Y N

Oral surgery? Y N

Periodontal treatment? Y N

Your teeth ground or the bite adjusted? Y N

A bite plate or mouth guard? Y N

Headaches, neck aches or shoulder aches? Y N

A serious/ difficult problem associated with any Y N

 previous dental work?
 If so, please describe, including cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A serious injury to the mouth or head? Y N

 If so, please describe, including cause: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Phen-Fen? Y N
(also known as Redux or Pondimin)

 If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever taken Fosamax? Y N
 If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else you would like for Dr. Michael Mostofi to know?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY:**

Your current dental health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Y N

Are you currently under a physician’s care? Y N

 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking any prescription/ over-the-counter drugs? Y N

 Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***For Women***: Are you taking birth control pills? Y N

Are you pregnant? Y N Week#: \_\_\_\_\_\_\_\_\_\_

Are you nursing? Y N

**Have you ever had any of the following disease or medical problems?**

 (Please circle all options that apply)

Y N Anemia/Radiation Treatment Y N Hemophilia/Abnormal Bleeding

Y N Artificial Bones/Joints/Valves Y N Hepatitis

Y N Arthritis Y N High/Low Blood Pressure

Y N Asthma Y N HIV+/AIDS

Y N Blood Transfusion Y N Hospitalized for Any Reason

Y N Cancer/Chemotherapy Y N Kidney Problems

Y N Congenital Heart Defect Y N Mitral Valve Prolapse

Y N Diabetes Y N Psychiatric Problems

Y N Difficulty Breathing Y N Severe/Frequent Headaches

Y N Drug/Alcohol Abuse Y N Shingles

Y N Emphysema/Glaucoma Y N Sickle Cell Disease/Traits

Y N Epilepsy/Seizures/Fainting Spells Y N Sinus Problems

Y N Fever Blisters/Herpes Y N Tuberculosis (TB)

Y N Heart Attack/Stroke Y N Ulcers/Colitis

Y N Heart murmur Y N Venereal Disease

Y N Heart Surgery/Pacemaker Y N Thyroid

Please list any serious medical condition(s) that you have ever had:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you allergic to any of the following?**

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine

Y N Jewelry/Metals Y N Tetracycline Y N Dental Anesthetics Y N Latex

Please list any other drugs/material that you are allergic to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OFFICE USE ONLY:

I verbally reviewed the medical/dental information above with the patient named herein.
Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Medical History Updates:

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_