   
  
 | **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

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

**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:\_\_\_\_\_\_\_\_\_\_