Patient Profile

Broadway Dental
Office of Pira Sadeghi

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Patient Information

Date ______________________________

First Name ______________________________

Last Name ______________________________

Email ______________________________

I prefer to be called ______________ ☐ Male ☐ Female

Birthday ______________________________

Age __________

SS # ______________________________

Address ______________________________

City ________________

State________

Zip__________

Home Phone # ______________________________

Cell # ______________________________

Work Phone # ____________ Extension ________

Employer ______________________________

Employer Address ______________________________

Occupation ______________________________

Whom may we thank for referring you? ______________

Other family member(s) seen by us? ______________

Spouse Information

First Name ______________________________

Last Name ______________________________

Birthday ______________________________

Work Phone # ____________ Extension________

Primary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name ______________________________

Address ______________________________

Phone ______________________________

Group or Policy # ______________________________

Insured's Name ______________________________

Relation ______________________________

Insured's Birthdate ______________________________

Insured's ID # ______________________________

Insured's Employer ______________________________

Secondary Insurance Coverage

Dental Coverage ☐ Yes ☐ No

Insurance Name ______________________________

Address ______________________________

____

Phone ______________________________

Group or Policy # ______________________________

Insured's Name ______________________________

Relation ______________________________

Insured's Birthdate __________ Insured's ID # __________

Insured's Employer ______________________________

Other Insurance Coverage

Do you have a Health Savings Account (HSA) or FLEX spending account?

☐ Yes ☐ No If yes, please provide information __________

____

____

Emergency Contact

In the event of an emergency, is there someone who lives near you that we should contact?

Name (Last/First/Middle) ______________________________

Relation ______________________________

Phone Number ______________________________

Initials __________

Patient History

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Medical History

Do you have a primary physician? ☐ Yes ☐ No

Physician's Name ____________________

Phone # ____________________

Date of last visit ____________________

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: ____________________

____

____

____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No Please list:__________

____

____

____

Have you ever taken Fosamax or any other bisphosphonate? ☐ Yes ☐ No

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

Yes	No		Yes	No	
☐	☐	Abnormal bleeding	☐	☐	Herpes/fever blisters
☐	☐	Alcohol/drug abuse	☐	☐	High blood pressure
☐	☐	Anemia	☐	☐	HIV/AIDS
☐	☐	Arthritis	☐	☐	Hospitalization
☐	☐	Artificial bones/joints/valves	☐	☐	Kidney problems
☐	☐	Asthma	☐	☐	Liver disease
☐	☐	Blood transfusion	☐	☐	Low blood pressure
☐	☐	Cancer/chemotherapy	☐	☐	Mitral valve prolapse
☐	☐	Colitis	☐	☐	Osteoporosis/osteopenia
☐	☐	Congenital heart defect	☐	☐	Pacemaker
☐	☐	Diabetes	☐	☐	Psychiatric treatment
☐	☐	Difficulty breathing	☐	☐	Radiation treatment
☐	☐	Emphysema	☐	☐	Rheumatic/scarlet fever
☐	☐	Epilepsy	☐	☐	Seizures
☐	☐	Fainting spells	☐	☐	Shingles
☐	☐	Frequent headaches	☐	☐	Sickle-cell disease/traits
☐	☐	Glaucoma	☐	☐	Sinus problems
☐	☐	Hay fever	☐	☐	Stroke
☐	☐	Heart attack	☐	☐	Thyroid problems
☐	☐	Heart murmur	☐	☐	Tuberculosis (TB)
☐	☐	Heart surgery	☐	☐	Ulcers
☐	☐	Hemophilia	☐	☐	Venereal disease
☐	☐	Hepatitis			

Medical History

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

____

____

Have you ever taken a dietary pill such as Fen Phen? __________

Please mark if you are allergic to any of the following.

☐ Aspirin	☐ Iodine	☐ Penicillin
☐ Anesthetics	☐ Jewelry	☐ Tetracycline
☐ Codeine	☐ Latex	☐ Sulfa
☐ Erythromycin	☐ Metals	

Please list any other drugs/materials you are allergic to:

____

____

____

For women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes, week # _______ ☐ No

Are you nursing? ☐ Yes ☐ No

Dental History

Why have you come to the dentist today? ____________________

____

Date of your last dental visit____________________

Have you completed any orthodontic work? ☐ Yes ☐ No

Do you need antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have bad breath or a bad taste in your mouth? ☐ Yes ☐ No

Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Are you happy with your teeth and smile? ☐ Yes ☐ No

If not, please tell us why: ____________________

____

Would you like whiter teeth? ☐ Yes ☐ No

Do you have clicking or popping in your jaw? ☐ Yes ☐ No

Do you have pain around your ear? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Do you smoke or use tobacco in any form? ☐ Yes ☐ No

Initials __________

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A few last questions

Have you ever had any of the following:

Yes No
☐ ☐ Clicking or popping jaw
☐ ☐ Jaw pain or tiredness
☐ ☐ Lip or cheek biting
☐ ☐ Orthodontic treatment
☐ ☐ Pain around the ear

Do you use a CPAP machine when sleeping? ☐ Yes ☐ No
Do you have pain in your jaws? ☐ Yes ☐ No
Do you hear noises in your jaw joint? ☐ Yes ☐ No
Has your jaw ever locked open or closes? ☐ Yes ☐ No
Do you have difficulty opening wide or yawning? ☐ Yes ☐ No
Do you get headaches? ☐ Yes ☐ No
Do you have trouble sleeping soundly? ☐ Yes ☐ No
Is your jaw tired when you wake up? ☐ Yes ☐ No
Are your teeth sore when you wake up? ☐ Yes ☐ No
Do you think you grind your teeth? ☐ Yes ☐ No
Do you clentch your teeth? ☐ Yes ☐ No
Do you snore? ☐ Yes ☐ No

Reviewed by:

Doctor Signature

Date

Patient Agreement

Payment

I understand that the information 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 services that I may need during diagnosis and treatment with my informed consent. I authorize the dental staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by all doctors and associates at Broadway Dental to make a thorough diagnosis. The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Signature

Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Appointment Policy

In order to render quality care for your dental needs, we must commit the doctor's time for you. Please take only those appointments which you can keep.

We do have a courtesy call a day before your appointment and Monday appointments are confirmed on Friday. We ask you to give us 2 or 3 good phone numbers where you could be reached.

Should you break your appointment without at least a 24 hour or 1 business day notice, we will be unable to appoint another patient in your place. In this case, there will be a charge of $100. To cancel a Monday appointment, you must notify us by the preceding Friday at the latest.

Thank you for your cooperation.

Signature (Guardian's signature if patient is under the age of 18.)

Date