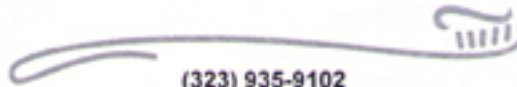


DANNY SHIRI, D.D.S.

Cosmetic and Implant Dentistry



(323) 935-9102

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PATIENT INTRODUCTION & HEALTH HISTORY

DATE _____

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program. In order to do this we must know as much about you as we do about your teeth. ALL INFORMATION, OF COURSE, WILL BE HELD IN STRICT CONFIDENCE.

PATIENT

Name _____ Email _____

If child: Parent's Name _____ Cell Phone _____

Date of Birth _____ Age _____ Home Phone _____

Address _____ City _____ Zip Code _____

Employed by _____ Position _____ Business Phone _____

Business Address _____ City _____ Zip Code _____

S/S # _____ D/L # _____

SPOUSE

Name _____

Employed by _____ Position _____ Business Phone _____

Business Address _____ City _____ Zip Code _____

Convenient Appointment Time _____

Are you available for appointments on short notice? _____

Is another member of your family, or relative a patient at our office? _____

In case of emergency, who should be notified? _____ Phone _____

DENTAL INSURANCE

Name of Insured _____ Employer _____

I.D. or S/S # of Insured _____ Birthdate _____ Relationship _____

Insured Co. _____ Group/Plan No. _____ Effective Date _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DO YOU HAVE, OR DID YOU EVER HAVE, ANY OF THE FOLLOWING?

Cardiovascular:

YES/NO

- Mitral Valve Prolapse
- High blood pressure
- Heart disease from childhood
- Heart murmur
- Rheumatic fever
- Use of Phen-Fen
- Pacemaker
- Vascular graft
- Heart valve replacement
- Heart attack
- Heart surgery
- Congestive heart failure
- Angina (chest pain)
- Irregular heart beat
- Stroke
- Increased cholesterol

Respiratory:

YES/NO

- Asthma
- Emphysema
- Tuberculosis
- Other _____

**Endocrine/Hematologic/
oncologic/Immune:**

YES/NO

- Diabetes
 - Thyroid disease
 - Hemophilia
 - Sickle cell disease
 - Bleeding tendency
 - Anemia
 - Cancer
 - Radiation therapy
 - Chemotherapy
 - HIV infection/AIDS
 - Organ transplant
 - Blood transfusion
- GI/GU:**
- YES/NO
- Hepatitis (A,B,C, or other?)
 - Kidney dialysis
 - Ulcers
 - Sexually transmitted disease
 - Denied permission to give blood

**Musculo-Skeletal/CNS/
Development:**

YES/NO

- Joint replacement
- Osteoarthritis
- Rheumatoid arthritis
- Spinal cord injury
- Seizures
- Cerebral palsy
- Mental retardation
- Dementia

Psychological:

YES/NO

- Anxiety/Nervousness
- Depression
- Mental health treatment
- Eating disorder

Social:

YES/NO

- Do you use tobacco products?
- Do you drink alcohol?
- Every day? If so, how much? _____
- Do you use recreational drugs?

1. Are you allergic to: ___Penicillin ___Codeine ___Novocaine ___Aspirin ___Sulfa ___Latex ___Other _____
2. Presently taking medication? _____ Please list: _____
3. Date of last physical exam _____
4. Are you now under the care of a physician? _____ if so for what condition _____
5. Name of physician _____ Phone _____
6. Do you smoke? _____
7. Have you had any serious illness or operation _____ if so what _____
8. Any other disease or condition not listed _____
9. Woman Are you pregnant? _____ Are you breast feeding now? _____ Are you taking birth control pills? _____
10. Have you ever been premedicated with antibiotics for dental treatment? _____

DENTAL HISTORY

- What concerns you most? _____
- Are you having discomfort at this time? _____ What is the discomfort? _____
- How long since you have been to a dentist? _____ What was done then? _____
- Did you have X-Rays? _____ How often did you visit a dentist before then? _____
- Have you lost any teeth? _____ Any complications with extractions? _____
- Are your teeth sensitive to: heat _____ cold _____ sweets _____ sour _____
- Have you ever had your teeth straightened? _____ When? _____
- How often do you brush your teeth? _____ Do you use dental floss? _____
- Do you have bleeding gums? _____ Where? _____
- Have you ever had gum treatment? _____ When? _____
- Does food wedge between your teeth? _____ Where? _____
- Do you grind or clench your teeth? _____ When? _____
- Do you have any pain around your ear? _____ Do you hear popping or clicking noises when you chew? _____
- Any swelling or lump in your mouth? _____
- Do you have any fear of having dentistry done? _____
- How do you feel about the appearance of your teeth? _____

To the best of my knowledge all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. I am directly and fully responsible for payment submitted by doctor for services rendered. If this account is assigned for collection and/or suit, collection cost and interest and/or Attorney fee and court costs will be added to the amount due. Any returned check will incur bank fees. I hereby authorize Dr. Danny Shiri to perform any and all treatment for myself or child (if patient is a minor). I also consent to such methods, X-rays, drugs, and agents as may be indicated in the connection with treatment. This consent will remain in effect until cancelled.

Signature of Patient or Guardian _____ Date _____