Neeshat S. Khan, D.D.S.

Family General & Cosmetic Dentistry
Endodontics, Implants & Orthodontics
21672 Granada Avenue
Cupertino, CA 95014
Telephone (408) 777-1290

Dental History

What is the reason for your visit today?____

Date of Last Dental Visit?_______ **Last Dental Cleaning**________ **Last Full Mouth X-rays**________

What was done at your last dental visit?____

Previous Dentist's Name____

Address______________________________ State____________ Zip___________

Telephone____

How often do you have dental examinations?______________________________

How often do you brush your teeth?____________ How often do you floss?______________

What other dental aids do you use? (Interplak, toothpick, etc.)________________________

Do you have any dental problems now? **Yes No**

If yes, please describe:____

Are any of your teeth sensitive to:

Hot or Cold? **Yes No**

Sweets? **Yes No**

Biting or Chewing? **Yes No**

Have you noticed any mouth odors Or bad tastes? **Yes No**

Do you frequently get cold sores, blisters Or any other oral lesions? **Yes No**

Have you ever had:

Orthodontic treatment? **Yes No**

Oral Surgery? **Yes No**

Periodontal treatment **Yes No**

Your teeth ground or the bite adjusted? **Yes No**

A bite plate or mouth guard? **Yes No**

A serious injury to the mouth Or head? **Yes No**

If so, please describe, including cause________

____

Do your gums bleed or hurt? **Yes No**

Have your parents experienced gum disease Or tooth loss? **Yes No**

Have you noticed any loose teeth or change In your bite **Yes No**

Does food tend to become caught in between Your teeth? **Yes No**

If yes, where?__________________________

Have you experienced:

Clicking or popping of the jaw? **Yes No**

Pain (joint, ear, side of face) **Yes No**

Difficulty in opening or closing the mouth? **Yes No**

Headaches, neck aches, or shoulder aches? **Yes No**

Sore muscles (neck, shoulders)? **Yes No**

Do you:

Clench or grind your teeth while asleep Or awake? **Yes No**

Bite your lips or cheeks regularly? **Yes No**

Hold foreign objects with your teeth? (pencils, pipe, pens, nails, fingernails) **Yes No**

Mouth breathe while asleep or awake? **Yes No**

Have tired jaws, especially in the morning? **Yes No**

Smoke/chew tobacco? **Yes No**

Are you satisfied with your teeth's appearance? **Yes No**

Would you like to keep all of your teeth all of your life? **Yes No**

Do your feel nervous about having dental treatment? **Yes No**

If so, what is your biggest concern?

____

Have you ever had an upsetting dental Experience? **Yes No**

If yes, please describe________________

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe____

____

III. Have you had or do you have any of the following? (Please Circle)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis (A,B,C)
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin Disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema/lung diseases	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic Surgery	Eating disorders	Tuberculosis

IV. Are you allergic to or have had a reaction to any of the following? (Please Circle)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine)	Latex	Food
Nitrous oxide	Erythromycin	Metal

Others:____

V. Are taking or have you taken any of the following in the last three months? (Please Circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medications	Alcohol	Supplements
Weight loss medications	Biphosphonate (Fosamax)	Aspirin

Please list:____

VI. Women only.

Are you: **Pregnant?** Yes,___Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

VII. All patients.

Yes No Do you have or have you had any other diseases or medical problems Not listed?
If yes, please explain:______________________________

Yes No Have you ever been pre-medicated for dental treatment? If yes, why____________

Yes No Do you use more than two pillows to sleep?

Yes No Have you lost or gained more than 10 pounds in the past year?

Yes No Is there any issue or condition you'd like to discuss with the dentist in private?

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.

Patient's Signature:______________________________ Date:________________

Physician's Name:______________________________ Phone Number:____________

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health or medication. Further, I will not hold my dentist or any member of her staff, responsible for any errors or omissions I may have made in completion of this form.

____

Signature of Patient (Parent/Guardian) Date Signature of Dentist Date

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Confidential Medical Health History

Patient Name:________________________ Date of Birth:____________

I. Circle Appropriate Answer (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain________________________
   Physician's Name________________ Phone____________
   Address____________ City________ State_____ Zip ______
2. Yes No Have you taken any medication or drugs during the past two years?
   If YES, explain________________________
3. Yes No Has there been a change in your health within the last year?
   If YES, explain________________________
4. Yes No Have you gone to hospital or emergency room or had a serious illness in the last 5 years?
   If YES, explain________________________
5. Yes No Are you being treated by a physician now? If YES, explain____________
   Date of last medical exam?__________ Reason for exam:____________
6. Yes No Have you had problems with prior dental treatment?
   If YES, explain________________________
   Date of last dental exam?________ Name of last treating dentist:__________
7. Yes No Are you in pain now?
   If YES, explain________________________
8. Yes No Have you ever taken prescription medications for weight loss (diet pills)?
   If YES, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)

II. Have you experienced any of the following? (Please Circle)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent cough	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT(For Dependents)

NAME: ______________________________
SOCIAL SECURITY # : ____________ RELATIONSHIP TO PATIENT : ________
ADDRESS : ____________________ CITY : __________________
HM PHONE # : ________________ WK PHONE # : ________________

EMERGENCY CONTACT PERSON

NAME : ______________ **PHONE # :** __________ **PAGER/CELL # :** ________

ADDRESS : ____

____

IS A MEMBER OF YOUR FAMILY A PATIENT AT THIS OFFICE?
NAME : __________________ RELATIONSHIP : ______________
PERSON WHO REFERRED YOU TO US
NAME : ________________

CONSENT FOR TREATMENT

I hearby authorize Dr. Neeshat S. Khan or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Dr. Khan to make a thorough diagnosis of my dental needs.

Upon such diagnosis I authorize Dr. Khan to perform all recommended treatment mutually agreed by me and to employ such assistance as required to provide proper care.

I agree to use anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates. I understand that a 2.0% monthly late charge may be added to my account. If required, I also understand a check of my credit history may be made.

PATIENT SIGNATURE: __________________________ Date: ______

RESPONSIBLE PARTY SIGNATURE : ________________________

WITNESS : ____________________________

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PATIENT REGISTRATION FORM

DATE :__________

NAME:____
LAST FIRST MI

ADDRESS: ____

____
CITY STATE ZIP

SOCIAL SECURITY # : ______________ DRIVER LIC. # ______________
HOME PH # __________ WK PH # __________ PAGER/CELL # __________
BIRTHDATE : ____________AGE: ________ MALE/FEMALE(CIRCLE)
MARRIED/SINGLE/DIVORCED/WIDOWDED (CIRCLE)
EMAIL ADDRESS______________________________________

DENTAL PRIMARY INSURANCE

INSURANCE COMPANY: ______________________________
GROUP NUMBER : ______________________________
EMPLOYER NAME : ______________________________
INSURED'S NAME : ______________________________
DATE OF BIRTH : ________ RELATIONSHIP TO PATIENT:__________
INSURED'S ID NO. ______________
INSURED'S SOCIAL SECURITY # : ____________________

DENTAL SECONDARY CARRIER

INSURANCE COMPANY :______________________
GROUP NUMBER : ______________________
EMPLOYER NAME : ______________________
INSURED'S NAME : ______________________
DATE OF BIRTH : ________ RELATIONSHIP TO PATIENT:______
INSURED'S ID NO. ____________
INSURED'S SOCIAL SECURITY # : ______________

PLEASE CONTINUE ON NEXT PAGE