



Ronald W. Zartarian, D.M.D., F.A.G.D.
General, Aesthetic & Implant Dentistry

PATIENT INFORMATION FORM

The benefits of a healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health for a lifetime. Please read this form thoroughly and complete. The better we communicate, the better we can care for you. This information is necessary and will be confidential.

PLEASE PRINT LEGIBLY

GENERAL INFORMATION

Date: _____

Full Name: Dr. Mrs. Mr. Ms. _____
Last First MI Nickname/Preferred Name

Address: _____ Home Phone # _____
& Street City State Zip Code Cell # _____
FAX # _____
Pager # _____

Birth Date _____ Social Security Number _____ E-Mail (Optional) _____

Occupation _____ Employer _____

Business Address _____
& Street City State Zip Code (Area Code) Telephone Work

Marital Status: **Single** **Married** **Divorced** **Widowed** **Separated**

Spouse's Name _____

Spouse's Occupation _____ Employer _____

Person Financially Responsible _____
Name Relationship to Patient Social Security #

Address Telephone
Who may we thank for referring you to us? _____

Former Dentist _____ Date of Last Visit _____

Reason for Today's Visit _____
Former Dentist's Address

Who may we contact in case of emergency? _____
Name Relationship (Area Code) Telephone #

In case of cancellations are you available on short notice? _____

Most convenient appointment times: _____ AM _____ PM _____ Evening _____ Saturday

Can you receive telephone calls at work? _____ YES _____ NO **Page 1 of 4**

Fellow, Academy of General Dentistry

INSURANCE INFORMATION

If you have any type of dental insurance, please complete the following:

Name & Address of Insurance Carrier _____

Telephone Number of Carrier (if available) _____

Primary Subscriber Name _____ Date of Birth _____

Social Security # _____

Group # _____ ID # _____

Employer Name _____ Address _____

Patient's Relationship to Subscriber: Self Spouse Child Other _____

Is patient covered by another plan? Yes No

If so, Name & Address of Carrier _____

Telephone Number (if available) _____

Group # _____ ID# _____

Does Patient have **Medical Insurance**? Yes No

If so, Carrier Name and Address _____

Telephone Number (if available) _____

Group # _____ ID # _____

HEALTH INFORMATION

For the following questions, circle yes or no, whichever applies. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

- 1.
2. Has there been any change in your general health within past year?..... Yes No
3. Your last physical examination was on: _____
4. Are you now under the care of a physician?..... Yes No
If so, what is the condition being treated: _____
5. The name and address of your physician: _____

6. Have you had any serious illness, operation or been hospitalized in the past 5 years? Yes No
7. Are you taking any medication(s) including non-prescription medication?..... Yes No
If so, what medication(s) are you taking: _____
8. Do you have or have you had any of the following diseases or problems?
 - A. Damaged heart valves or artificial heart valves, including heart murmur or rheumatic heart disease..... Yes No
 - B. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke)..... Yes No
 1. Do you have chest pain upon exertion? Yes No
 2. Are you ever short of breath after mild exercise or when lying down?..... Yes No
 3. Do your ankles swell?..... Yes No
 4. Do you have inborn heart defects?..... Yes No
 5. Do you have a cardiac pacemaker?..... Yes No
 - C. Allergy Yes No
 - D. Sinus Trouble..... Yes No
 - E. Asthma or hay fever Yes No
 - F. Fainting spells or seizures..... Yes No
 - G. Persistent diarrhea or recent weight loss..... Yes No
 - H. Diabetes..... Yes No
 - I. Hepatitis, jaundice or liver disease..... Yes No
 - J. AIDS or HIV Infection..... Yes No
 - K. Thyroid problems Yes No
 - L. Respiratory problems, emphysema, bronchitis, etc..... Yes No
 - M. Arthritis or painful joints..... Yes No
 - N. Stomach ulcer or hyper acidity..... Yes No
 - O. Kidney trouble Yes No
 - P. Tuberculosis Yes No
 - Q. Persistent cough or cough that produces blood..... Yes No
 - R. Persistent swollen glands in neck..... Yes No
 - S. Low blood pressure..... Yes No
 - T. Sexually transmitted disease..... Yes No
 - U. Epilepsy or other neurological disease..... Yes No
 - V. Problems with mental health..... Yes No
 - W. Cancer..... Yes No

- | | | | |
|-----|---|-----|----|
| 9. | Have you had abnormal bleeding?..... | Yes | No |
| | A. Have you ever required a blood transfusion? | Yes | No |
| 10. | Do you have any blood disorders such as anemia? | Yes | No |
| 11. | Have you ever had any treatment for a tumor or growth? | Yes | No |
| 12. | Are you allergic or have you had a reaction to: | | |
| | A. Local anesthetics | Yes | No |
| | B. Penicillin or other antibiotics | Yes | No |
| | C. Sulfa drugs | Yes | No |
| | D. Barbiturates, sedatives, or sleeping pills | Yes | No |
| | E. Aspirin..... | Yes | No |
| | F. Iodine..... | Yes | No |
| | G. Codeine or other narcotics..... | Yes | No |
| | H. Other _____ | | |
| 13. | Have you ever had any serious trouble associated with any previous dental treatment?
If so, explain _____ | Yes | No |
| 14. | Do you have any disease, condition, or problem not listed above that you think I
Should know about?.....
If so, explain _____ | Yes | No |
| 15. | Are you wearing contact lenses?..... | Yes | No |
| 16. | Are you wearing removable dental appliances?..... | Yes | No |

Women

- | | | | |
|-----|--|-----|----|
| 17. | Are you pregnant?..... | Yes | No |
| 18. | Do you have any problems associated with your menstrual period?..... | Yes | No |
| 19. | Are you nursing?..... | Yes | No |
| 20. | Are you taking birth control pills?..... | Yes | No |

Chief Dental Complaints: _____

PHOTOGRAPH RELEASE

Photographs of treatment may be necessary for display, documentation or educational purposes. I recognize that I have the option of not being identified by these photographs.

Identification Permission Granted YES NO

I certify that I have read and understand all of the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold Dr. Ronald Zartarian, or any member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

 Signature of Patient (Patient/Guardian for Minors)

 Ronald W. Zartarian, D.M.D.