Drs. Vijeh & Quist

1206 The Alameda, Berkeley, CA 94709
(510) 525-7521 Fax (510) 525-5262

Patient Information

Today's Date: _____ Pronoun _____ ☐Male ☐Female

NAME: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

Birthdate: ____ / ____ / ____ Age: _____

Home Address: _____ APT/CONDO #

_____
CITY STATE ZIP

Hm# (____) _____ Cell/Other #: _____

Wk: (____) _____

E-Mail address: _____

Employer: _____

Employer Address: _____

_____

How long there? _____ Occupation: _____

Name of Spouse / Partner _____

Time to reach you? Day _____ Night _____

Whom may we thank for referring you? _____

Previous dentist: _____

Last Visit Date: _____

Full time student? ☐ Yes ☐ No

Name of school _____ City _____

Person Responsible for Account

His/Her Name: _____

Employer: _____

Wk: (____) _____ Ext: _____

Birthdate: ____ / ____ Relation: _____

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

His/Her Name: _____

Wk: (____) _____ Ext: ____ Hm# (____) _____

Relation: _____

Primary Dental Insurance

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone # _____

Group # (Plan, Local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone # _____

Group # (plan, local or Policy#) _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____ / ____ / ____

Insured's Employer: _____

I Understand . . .

Your appointment time is reserved ***only*** for you. We do not double book except for emergency patients. If you need to change your appointment, you must notify us one business day in advance (i.e.: To change a Monday appointment you must notify us the previous Friday morning). A fee based on appointment time reserved will be charged for ***late*** cancellations or missed appointments.

Payment in full is required at the time of service. For patients with dental insurance, we will require your copayment and we will bill your insurance company for you. For your convenience we accept personal checks, Visa and Mastercard. Unpaid balances will be billed to your credit card on file.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to claim.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity

_____
Signed (patient, or parent if minor) Date

MEDICAL HISTORY

	YES	NO		YES	NO
Are you in good health at the present time?	❑	❑	Do you bruise easily?	❑	❑
Are you under current medical treatment?	❑	❑	Are you on a special diet?	❑	❑
Are you taking any medication? List Medication(s)	❑	❑	If female, are you pregnant?	❑	❑

Please check any of the following conditions you have, or have had:

- ❑ Heart Valve Defect (murmur)
- ❑ High or Low Blood Pressure
- ❑ Emotional Problems
- ❑ Artificial Joint Replacement
- ❑ Injury to teeth or jaw
- ❑ Artificial Heart Valves
- ❑ Dizziness or Fainting
- ❑ Radiation Treatment
- ❑ Epilepsy
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ Endocarditis
- ❑ Convulsions
- ❑ T.B.
- ❑ Asthma
- ❑ Osteopenia or Osteoporosis
- ❑ Rheumatic Fever
- ❑ Diabetes
- ❑ Hepatitis
- ❑ Ulcer
- ❑ Immune System Disorder
- ❑ Thyroid Disorder
- ❑ Cancer(s)

Date of last Physical Exam _____

Name of Physician(s) _____

Address _____

Please check allergies to any of these:

- ❑ Antibiotics
- ❑ Aspirin
- ❑ Codeine
- ❑ Novocaine
- ❑ Demerol
- ❑ Penicillin
- ❑ Antihistamines
- ❑ Barbiturates
- ❑ Sulfa
- ❑ Latex
- ❑ Ibuprofen

Please list past serious illness, injuries, and operations:

_____

_____

_____

Have you ever taken the diet drug combination "Fen-Phen"? Yes _____ No _____

Are you or have you ever taken medication for Osteoporosis or Osteopenia? Yes_____ No_____

DENTAL HISTORY

Date of last dental cleaning and examination: _____

By Dr.: _____ City: _____

	YES	NO	UPDATE
Was all your treatment completed at that time?	❑	❑	
Chief dental complaint today? _____	❑	❑	
Are you in dental pain now? Lately?	❑	❑	
Are there any sores or growths in your mouth?	❑	❑	
Do your gums bleed easily?	❑	❑	
Have you ever received treatment for gum disease?	❑	❑	
Do you have any sensitive teeth or chew only on one side of your mouth?	❑	❑	
Have you ever had your teeth straightened?	❑	❑	
Have you ever had prolonged bleeding after a cut or an extraction?	❑	❑	
Are you unhappy with the appearance of your teeth?	❑	❑	
Are you aware of clenching or grinding your teeth?	❑	❑	
Do you smoke?	❑	❑	
Do your jaws click when you open your mouth widely?	❑	❑	
Are you prone to headaches?	❑	❑	
Have you ever had an unfavorable dental experience?	❑	❑	
Do you object to the use of local anesthetics: "Novocaine"?	❑	❑	
Do you wish to use Nitrous Oxide during treatment?	❑	❑	

_____

Signature Date