



S. Aghassibake, D.D.S.
 1655 E. Thousand Oaks Blvd., Suite 204
 Thousand Oaks, California 91362-2800
 Tel. ☎ 805.449.2552 ☐ Fax ☐ 805.449.2553

PATIENT REGISTRATION FORM

Date _____ / _____ / _____

A. Patient Information

Last name		First name		Middle Initial
Birthdate _____ / _____ / _____	Age	<input type="radio"/> Male <input type="radio"/> Female	Reason for visit	
Who may we thank for referring you to our office?				
Marital Status: S M W D	Please name other family members who have been our prior patients			

B. Responsible Party Information

Last name		First name		Middle Initial
Residence Address		City	State	Zip
Telephone No. (Res)	Telephone No. (Bus)		Relation to patient	
Employer Name/Address		Occupation	No. of yrs employed	
Social Security No.	Birthdate	License No.		

C. Responsible Party's Spouse

Last name		First name		Middle Initial
Telephone No. (Res)	Telephone No. (Bus)			
Employer Name/Address		Occupation	No. of yrs employed	
Social Security No.	Birthdate	License No.		

D. Emergency Contact Information

Last name		First name		Middle Initial
Address		City	State	Zip
Telephone No. (Res.)		Telephone No. (Bus.)		

E. Dental Insurance Information

Insured's Name	
Insurance Co. / Address	
Insured's Employer	
Insured's Social Security No.	Group No.

Acknowledgement

I understand that I am financially responsible for all charges: any deductible amount, co-payment, or any balance not paid for by my insurance company (if I have one.) Based on insurance information provided by me, Aesthetic Dental Group can prepare a treatment estimate reflecting estimated patient portions due at the time of service.

I understand that if this account is assigned to an attorney for collection, Aesthetic Dental Group shall be entitled to reimbursement of attorney fees and costs of collection. I understand that a finance charge of 1.5% per month may be charged to my account on any unpaid balance over 30 days.

I agree to give 24-hour notice for cancellations or pay the broken appointment fee. I understand that leaving a message after the office is closed the day (or weekend) before is not sufficient notice.

I understand the importance of a truthful health history to assist the doctor in providing the best care possible.

I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform dental treatment and administer any necessary medication that may be indicated. I also understand that all dental procedures and the use of anesthetic agents carry a certain risk.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosures of my patient record and agree to release all necessary protected health information needed to carry out treatment, payment activities and healthcare operations.

I authorize Aesthetic Dental Group to verify my credit with a consumer reporting agency.

Signature _____ Date _____

PATIENT HEALTH HISTORY FORM

Please circle yes or no to all of the questions that apply to you.
Your answers are for our records only and will be considered confidential.

F. Medical History			
1. Are you in good health?	Y	N	
2. Has there been any change in your health in the past year?	Y	N	
3. Are you under the care of a physician? If yes, for what condition?	Y	N	
4. Physician's name, address and phone number			
5. Have you had any serious illness or hospitalization?	Y	N	
6. Are you using any of the following?	Y	N	
a. Antibiotics _____	Y	N	
b. Anticoagulants (blood thinners) _____	Y	N	
c. Aspirin or drugs such as Motrin, Aleve, Ibuprofen _____	Y	N	
d. High blood pressure medications _____	Y	N	
e. Steroids (Cortisone, etc.) _____	Y	N	
f. Tranquilizers _____	Y	N	
g. Insulin or oral anti-diabetic drugs _____	Y	N	
h. Digitalis, Inderal, Nitroglycerin or other heart drug _____	Y	N	
i. Please list any and all medications taken, including prescription or over-the-counter medications, herbal or holistic remedies, vitamins or minerals:			
7. Height _____		Weight _____	
8. Do you have or have you had any of the following:	Y	N	
a. Damaged heart valves, artificial heart valves or heart murmur _____	Y	N	
b. Rheumatic heart disease _____	Y	N	
c. Heart trouble, heart attack, angina _____	Y	N	
d. Chest pain, shortness of breath, swelling of ankles _____	Y	N	
e. High blood pressure _____	Y	N	
f. Stroke _____	Y	N	
g. Allergies _____	Y	N	
h. Sinus trouble _____	Y	N	
i. Fainting spells or seizures _____	Y	N	
j. Diabetes _____	Y	N	
k. Hepatitis, jaundice, liver disease _____	Y	N	
l. Thyroid problem _____	Y	N	
m. Respiratory problems, emphysema, bronchitis _____	Y	N	
n. Asthma _____	Y	N	
o. Arthritis, swollen joints _____	Y	N	
p. Stomach ulcers or hyperactivity _____	Y	N	
q. Kidney trouble _____	Y	N	
r. Tuberculosis _____	Y	N	
s. Persistent cough _____	Y	N	
t. Implants placed anywhere in your body (i.e., heart valve, pacemaker, hip, knee) _____	Y	N	
u. Cancer _____	Y	N	
v. Radiation (X-ray) treatment for cancer _____	Y	N	
w. Any disease, (i.e. HIV), drug or transplant operation that has depressed your immune system? _____	Y	N	
x. Glaucoma _____	Y	N	
y. Emotional or psychiatric problems _____	Y	N	
z. Alcohol or chemical dependency _____	Y	N	

9. Have you had abnormal bleeding?	Y	N
a. Have you required a blood transfusion?	Y	N
10. Do you have any blood disorder such as anemia?	Y	N
Do you bruise easily?	Y	N
11. Are you allergic to or have had a reaction to:	Y	N
a. Local anesthetics _____	Y	N
b. Penicillin or other antibiotics _____	Y	N
c. Sulfa drugs _____	Y	N
d. Barbituates or sleeping pills _____	Y	N
e. Aspirin _____	Y	N
f. Iodine _____	Y	N
g. Codeine or other narcotics _____	Y	N
h. Latex or rubber products _____	Y	N
i. Other _____	Y	N
12. Have you or an immediate family member had any problem with intravenous anesthesia?	Y	N
13. Do you smoke or chew tobacco?	Y	N
Tobacco consumed _____ per day for _____ years		
Alcohol consumed _____ daily _____ weekly _____ monthly		
14. Do you have any other condition or disease you think the doctor should know about?	Y	N
15. Do you wish to speak privately with the doctor about anything?	Y	N
Women		
16. Are you pregnant? _____	Y	N
17. Are you nursing? _____	Y	N
18. Are you taking birth control pills? _____	Y	N
If so, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed.		

G. Dental History		
1. How long has it been since you have seen a dentist?		
2. Date of last complete dental exam		
3. Date of last full mouth x-rays		
4. Have you had any periodontal (gum) treatments?	Y	N
5. Do your gums bleed?	Y	N
6. Are your teeth sensitive to hot, cold, sweets or pressure?	Y	N
7. Are you aware of grinding or clenching your teeth?	Y	N
8. Do you have headaches, ear ache or neck pain?	Y	N
9. Are you unhappy with the appearance of your teeth?	Y	N
10. Have you worn braces on your teeth?	Y	N
11. Do you have discolored teeth that bother you?	Y	N
12. Would you like your smile to look different?	Y	N
13. Do you regularly use dental floss?	Y	N
14. Have you had any serious problems associated with any previous dental treatment?	Y	N