

# DR. A. NOORANI DENTISTRY, PC

## Patient Information

Name \_\_\_\_\_  
Last First Middle Sex Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Social Security# \_\_\_\_\_  
MM-DD-YYYY 999-99-9999

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

General Dentist \_\_\_\_\_ Last Visited \_\_\_\_\_

Who may we thank for referring you to our office \_\_\_\_\_

## Spouse / Additional Contact Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Address \_\_\_\_\_  
Street City State Zip

Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ ext. \_\_\_\_\_  
999-999-9999 999-999-9999 999-999-9999

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

## Insurance Information

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_  
999-99-9999

Policy Owner's Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Policy Owner's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. (plan, local, or policy) \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

## Secondary Insurance

Policy Owner's Name \_\_\_\_\_ Policy Owner's Social Security # \_\_\_\_\_  
999-99-9999

Policy Owner's Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
MM-DD-YYYY

Policy Owner's Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. (plan, local, or policy) \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Insurance Phone No. \_\_\_\_\_

# Medical History

Are you under the care of a physician? Yes No If Yes, explain \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_ Last Visit \_\_\_\_\_

Address \_\_\_\_\_

Are you pregnant Yes No If so how many weeks \_\_\_\_\_

Have you tonsils or adenoids been removed? Yes No

Have you ever experienced jaw joint pain/ discomfort (TMJ/TMD)? Yes No

Do you have any missing or extra permanent teeth? Yes No

Have you ever had an injury to : (select all that apply) Teeth Mouth Chin

Do you have speech problems? Yes No if Yes, explain \_\_\_\_\_

Do your gums bleed? Yes No Do you smoke? Yes No Do you like your smile? Yes No

Does/Have you ever had any of the following habits?	Lip Sucking/Biting	Nail biting	Prolonged Bottle/Pacifier
Clenching/Grinding Teeth	Mouth Breather	Tongue Thrusting	Thumb/ Finger Sucking

Are you allergic to any of the following?

Aspirin Erythromycin  
Codeine Penicillin  
Tetracycline Latex  
Any Metals/Plastics

Other Allergies/Sensitivities:  
\_\_\_\_\_

List all drugs you are currently taking

List any serious medical condition(s) treated

## Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand that where appropriate, credit bureau reports may be obtained.

Name of person filling out this form \_\_\_\_\_ Date \_\_\_\_\_