TIRDAD FATTAHI, D.D.S., P.C.
Family & Cosmetic Dentistry

4840 MacArthur Blvd., NW, Suite 101
Washington, DC 20007
(202) 338-7499

Welcome, we are glad you have selected us to provide dental care for you and your family. Please answer the following questions and sign at the end. PLEASE PRINT.

PATIENT INFORMATION

_________ ____ ____________
Date Last First Middle Initial Preferred Name

Address____
Street City State Zip

Home Phone (___) ____________ **Work Phone** (___) ______________ **Cell Phone** (___) ______________

Birth date ____/____/____ **Social Security #** _____-____-_____ **E-mail address**________________________

Age _____ **Gender** _________ **Occupation** ________________ **Employer** _______________________

Marital status_______ **Spouse's Name** ________________________ **Occupation** ________________

If patient is a full time student; school name ____

Name of nearest relative not living with you____

Relationship_______________ **Phone** (____) __________________

Emergency Contact ____________________________________ **Phone** (____) __________________

RESPONSIBLE PARTY INFORMATION (If other than above)

Name ____ ___________
Last First Middle Marital Status

Mailing Address____
Street City State Zip

Home Phone (____) _____________ **Work Phone** (____) ______________ **Cell Phone** (___) ____________

Social Security # ____-___-____ **Birth date**_____/_____/_____ **Relationship to patient** _____________

Occupation ____ **Employer** _______________________

Spouse's Name _____________________ **Employer**___________________ **Occupation** _____________

Social Security # ____-___-____ **Birth date**_____/_____/_____ **Work Phone** (____) _______________

INSURANCE INFORMATION

Insured's Name ____________________ **Birth date**___/___/___ **Insured's Soc. Sec. #** _____-____-_____

Employer ____ **I.D. No.** _____________________________

Insurance Company ___________________________________ **Group No.** ______________________

Insurance Co. Address ____

Insurance Company Phone # (____) __________________

DENTAL INFORMATION

How did you hear about our office?_____________________________ Name: _______________________

When was your last visit to the dentist? _______________ Dentist Name ___________________________

What did you liked best about your previous dentist? ____

What didn't you like? ____

Are you experiencing any dental problems now? ____

Do your gums bleed when you brush? YES NO Do you grind or clench your teeth? YES NO

Are your teeth sensitive to heat or cold? YES NO To Pressure? YES NO To Sweets? YES NO

Do you smoke? YES NO Do you Floss? YES NO

How many times do you brush per day _____. Is your tooth brush SOFT____ MEDIUM ____ HARD____

How do you feel about the appearance of your teeth, the color, and your smile? ________________________

____.

Have you ever had any complication following dental treatment? YES NO If yes, please explain: ________

____

Medical Information

1. Are you having pain or discomfort at this time? ……………… YES NO
2. Have you been a patient in the hospital during the past two years? ……………… YES NO
3. Have you been under the care of a medical doctor during the past two years? ……………… YES NO
   Physician's Name ______________________ Phone No. (____) ______________
   Address:____
4. Have you taken any prescription medication or drugs during the past two years? ……………… YES NO
5. Are you now taking any drugs or medications? ……………… YES NO
   If YES, please list: ____
6. Are you sensitive or allergic to any medication or anesthetics? ……………… YES NO
   If YES, please list: ____
7. Please indicate which of the following you have had or have at the present. Circle "yes" or "no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip, knee, etc.)	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble	YES	NO	Hepatitis B	YES	NO
Angina Pectoris	YES	NO	Ulcers	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease	YES	NO	Diabetes	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema	YES	NO	Anemia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough	YES	NO	Hemophilia	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Allergies or Hives	YES	NO	Liver Disease	YES	NO
Arthritis/Rheumatism	YES	NO	Sinus Trouble	YES	NO	Yellow Jaundice	YES	NO
Systemic Lupus	YES	NO	Epilepsy or Seizures	YES	NO	Fainting or Dizzy spells.	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy	YES	NO	Chemotherapy	YES	NO
Drug Addiction	YES	NO	Nervousness	YES	NO	Tumors	YES	NO
Stroke	YES	NO	Developmentally Disabled	YES	NO	Hepatitis A (infectious)	YES	NO

8. Do you have or have had any disease, condition, or problem not listed? ……………… YES NO
   If YES, please list: ____

FOR WOMEN ONLY:
Are you pregnant?______ YES, what month?______ Are you nursing? ______ Are you taking birth control pills? _______

CONSENT

1. The undersigned hereby authorizes doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) ______________________.
   I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependants is mine, due and payable at the time of services unless other arrangements have been made prior to start of treatment.
4. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.
5. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
6. I acknowledge receipt of the HIPPA Practices Disclosure and all Office Policies and I hereby agree to follow them, to include Payment Policy, Appointment Policy.

Patient______________________________ Date______________ Witness ____________________

Parent or Responsible Party __________________________ Relationship to Patient ____________________

FOR OFFICE USE ONLY: Reviewed by Dr. __________________________ Date ________________

Office Use Only

Notes:____
____
____
____
____
____