DR. NAZANIN NARANI

General dentist: _____ Pre-med _____

Referred by: _____ Appointment Date: _____

Reason for Referral: _____

Xrays: ☐ with patient ☐ mailed ☐ no xrays Examination Fee: $_____

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Other

Name: _____ Date: _____
(last) (first) (initial)

Address: _____
(street) (city) (prov) (postal code)

Home phone: _____ Work phone: _____ Cell: _____

Date of Birth: _____ Age: ___ Sex: Marital Status: _____

Care Card #: _____ Email Address: _____

Employer: _____ Occupation: _____

Spouses Name: _____ Occupation: _____

Employer: _____ Phone: _____ Ext: _____

In case of emergency, please notify: _____ Relationship: _____ Phone: _____

PRIMARY DENTAL INSURANCE		SECONDARY DENTAL INSURANCE	
NAME OF INSURED:	DATE OF BIRTH M /D /Y	NAME OF INSURED:	DATE OF BIRTH M /D /Y
EMPLOYER:		EMPLOYER:	
INSURANCE CARRIER:		INSURANCE CARRIER:	
GROUP/POLICY NUMBER:	DIVISION	GROUP/POLICY NUMBER:	DIVISION
ID NUMBER OR SIN	DEP. NO.	ID NUMBER OR SIN	DEP. NO.

FOR ELECTRONIC CLAIM SUBMISSION

I authorize the release, to my insuring company plan administrator, the information contained in claims submitted electronically.

_____
Signature of patient or parent/guardian

- Payment for services is due after each appointment. We accept interac, cash, cheque, visa and mastercard.
- As a courtesy, all required insurance forms will be filled out by our office. We will forward them to the insurance company.
- Insurance coverage is arranged by you and/or your employer as a benefit. Please direct questions to your employer or directly to the insurance company. Patients are fully responsible for the insurance.
- Dr. Nazanin Narani requires a full 48 hour notice for appointment cancellation. Failure to show up as scheduled may result in a charge of $150.00 for missed surgery appointment and $100.00 for a missed hygiene appointment.

Date: _____ Signature of Patient: _____

Date: _____ Reviewed by: _____

MEDICAL HISTORY

Name: _____

Name of Physician _____ Date of Last Physical Examination: _____

Are you presently under a physician's care? ☐ yes ☐ no If yes, for what condition? _____

_____

What drugs/medication have you taken over the past year? _____

_____

Have you ever been hospitalized? ☐ yes ☐ no If yes, for what condition? _____

_____

Do you have or have you had any of the following?

	Yes	No
1. Hepatitis, jaundice, liver disease	___	___
2. Rheumatic fever	___	___
3. Heart murmur	___	___
4. Heart trouble or stroke	___	___
5. High or low blood pressure	___	___
6. Chest pain, swollen ankles or breath shortness?	___	___
7. Drug allergies or reactions?	___	___
If yes, what? _____		
8. Asthma, hay fever, sinus problems or allergies?	___	___
9. Epilepsy or seizures	___	___
10. Diabetes	___	___
11. Arthritis or rheumatism	___	___
12. Stomach or duodenal ulcers	___	___
13. Kidney disease	___	___
14. Venereal disease	___	___
15. Are you at risk for having contacted Aids?	___	___
16. Glaucoma	___	___
17. Cancer	___	___
18. Medical radiation treatments	___	___
19. Abnormal bleeding problems?	___	___
a. Take aspirin daily	___	___
b. Clotting problems	___	___
c. Other blood problems	___	___
20. Are you a nervous person?	___	___
Do you take medications for this condition?	___	___
21. Have you had any other serious illnesses or conditions that we should know about?	___	___
If yes, what? _____		
22. Do you smoke?	___	___
If yes, how much? _____		
WOMEN		
23. Are you pregnant?	___	___
24. Do you take birth control pills?	___	___
25. Are you post-menopause?	___	___
26. Do you have any problems with your menstrual cycle?	___	___

DENTAL HISTORY

Chief complaint: _____

Have you ever:

	Yes	No
1. Had any injury to your face or jaw?	___	___
If yes, what happened and when _____		
2. Had any pain anywhere in your face or jaw?	___	___
Where is the pain now? _____		
3. Had bleeding gums?	___	___
4. Had loose teeth?	___	___
5. Had bad breath?	___	___
6. Had under the gum cleaning with freezing?	___	___
If yes, when?	___	___
7. Seen the hygienist?	___	___
If yes how often? ___3mo ___4mo ___6mo		
8. Had gum surgery?	___	___
Which part of the mouth? _____		
9. Had sore or sensitive teeth?	___	___
Where is the pain now? _____		
10. How often do you brush? _____		
Do you use a hard brush _____ or soft brush _____		
11. Do you use other dental aids? Such as:		
___ floss ___ toothpicks ___ mouthwash		
___ water irrigation ___ proxabrush		
12. Had your teeth straightened?	___	___
13. Clenched or grinded your teeth?	___	___
14. Worn a night guard?	___	___

Date: _____ Signature of Patient: _____

Date: _____ Reviewed by: _____

word/admin/ptform