NEWPORT BAYVIEW DENTAL

KAVEH NIKNIA D.D.S.
3101 West Coast Hwy, Suite 309, Newport Beach , Ca. 92663 949-650-6111

CONFIDENTIAL PATIENT INFORMATION

PERSON RESPONSIBLE FOR PAYMENT:
Name: Last_____First_____MI____ Mr___Ms____Dr___
Married____Single___Other_____Now a patient here?_____Relationship to Patient_____
Birthdate_____Social Security#_____ ____ _____Driver's License_____
Address: Street_____City_____Zip_____
Phones: Home_____Cell or pager_____Work_____Ext_____
Employer_____Address of Employer_____
Date of Last Dental Visit_____ Procedure Performed at that Appointment_____
Referred to us by_____ Email _____
Reason for Leaving Last Dentist_____

PATIENT, IF NOT THE PERSON ABOVE:
Name: Last_____First_____MI___ Mr___Ms___Dr____
Married_____Single____Child_____Birthdate_____Social Security#_____ ___ _____
Address: Street_____City_____Zip_____
Phones: Home_____Cell or pager_____Work_____Ext_____
Phone of person you can be reached through_____best time to reach you_____
Spouse or Parents name_____If student, school:_____
Person to contact in case of emergency_____Phone_____

PRIMARY INSURANCE INFORMATION
Name of Insured_____Soc.Sec.#_____Relationship to Patient_____
Employer_____Address_____Phone_____
Carrier Name_____Address_____Phone_____
Group plan_____Group #_____Union Local#_____
Subscriber ID#_____Birthday_____

ADDITIONAL INSURANCE INFORMATION
Name of Insured_____Soc.Sec.#_____Relationship to Patient_____
Employer_____Address_____Phone_____Date employed_____
Carrier Name_____Address_____
Phone_____Group plan_____Group#_____
Subscriber ID#_____

STATEMENT OF RESPONSIBILITY AND RELEASE
I authorize the Dentist and the Dental office to release any information including the diagnosis and the records of treatment or examination rendered to myself or my dependant during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dental office the insurance benefits otherwise payable to me. I understand that my insurance carrier may pay far less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependant's behalf.

_____Date_____
Signature of Patient, or Parent if Minor

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PATIENT NAME AGE GENDER
DATE

_____ _____ M____F_____

_____

Please answer all questions and fill in blank spaces when indicated. Answers to the following questions are for our records only and will be confidential.

	YES	NO	COMMENTS
1. Has there been any change in your general health Within the past year?	_____	_____	
2. Are you in poor health?.....	_____	_____	
3.My last physical exam was on ___/____/_____			
4.Are you now under the care of a physician?...	_____	_____	
5.The name of my physician is _____ address_____ telephone_____			
6. Have you had any serious illness or operation?.. If so, what was it?_____	_____	_____	
7. Have you been hospitalized in the past 5 years? For what?_____	_____	_____	
8. Do you have or have you had any of the following diseases or problems:			
A. Damaged heart valves, or artificial valves....	_____	_____	
B. Congenital heart lesions or murmers.....	_____	_____	
C. Cardiovascular disease (heart trouble, heart Attack, coronary insufficiency or occlusion, High blood pressure, arteriosclerosis, stroke)	_____	_____	
D. Do you have a cardiac pacemaker?	_____	_____	
E. Have you taken Fen-Phen/Redux for For weight loss?.....	_____	_____	
F. Sinus trouble.....	_____	_____	
G. Fainting spells or seizures.....	_____	_____	
H. Diabetes.....	_____	_____	
I. Hepatitis, jaundice, or liver disease.....	_____	_____	
J. Stomach ulcers.....	_____	_____	
K. Kidney trouble.....	_____	_____	
L. Tuberculosis.....	_____	_____	
M. Low blood pressure.....	_____	_____	
N. Do you have prosthetic joint, implants, Bone plates or screws? If so, what_____	_____	_____	
9. Have you had abnormal bleeding associated with surgery, trauma, or dental extractions?.....	_____	_____	
10. Do you bruise easily?.....	_____	_____	
11. Do you have any blood disorder or anemia?	_____	_____	
12. Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips?.....	_____	_____	
13. Are you taking any drug or medication?..... If so, what_____	_____	_____	
14. Are you taking any of the following:			
A. Antibiotics or sulfa drugs.....	_____	_____	
B. Anticoagulants(blood thinners).....	_____	_____	
C. Medicine for high blood pressure.....	_____	_____	
D. Cortisone (steroids).....	_____	_____	

E. Tranquilizers……_____ _____
F. Aspirin……_____ _____
G. Insulin, or drugs for diabetes……_____ _____
H. Digitalis, nitroglycerin, or drugs for
Heart disease……_____ _____
I. Hormonal therapy……_____ _____
J. Other_____

15. Are you allergic to or have you reacted adversely to:
A. Local anesthetics……_____ _____
B. Penicillin or other antibiotics……_____ _____
C. Sulfa drugs……_____ _____
D. Barbiturates, sedatives, sleeping pills…_____ _____
E. Aspirin……_____ _____
F. Codeine or other narcotics……_____ _____
G. Latex, or rubber products……_____ _____
H. Other_____

16. Have you had any serious trouble with any previous dental treatment?……_____ _____
If so, explain_____

17. Do you have or have you been in contact with anyone at risk for the following:
A. Hepatitis
B. Tuberculosis
C. AIDS or HIV+……_____ _____

18. Are you pregnant……_____ _____
19. Are you nursing……_____ _____
20. Do you have any condition, problem, or disease not listed above that you believe I should know about?……_____ _____

If so, please explain_____

Date : _____ Patient Signature : _____

I have filled out this health questionnaire completely. I have advised you of all medical problems of which I am aware. I understand that each dentist is licensed by the board of dental examiners and utilizes independent professional judgment in rendering services to the public. I hereby certify that I have read the foregoing or have had it read to me. I further certify that I, the undersigned, consent to having x-rays taken of my mouth, oral examination, and whatever dental treatment agreed upon to be necessary or advisable.

_____

Signature of patient date

_____

Signature of doctor date