



**Shawn Taheri, DDS, MS**  
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**Patient Information**

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PATIENT NUMBER

Date of Birth  
 Social Security#

Patient's Name Male Female

Last First Middle

How do you wish to be addressed? Single Married Separated Divorced Widowed

Name of Insurance Co.

Address **Dental Insurance**  
1<sup>st</sup> Coverage

City State Zip Employee Name

Phone Work Ext. Employer Name

Fax Cell Phone

Email Policy #

Union or Group

Employer **Dental Insurance**  
2<sup>nd</sup> Coverage

Position How Long Name of Insurance Co.

Address City State Zip Employee Name

City State Zip Employer Name

Spouse Name Phone

Social Security# Policy #

Employer Union or Group

Position How long

**RELEASE:**  
 I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Responsible Party  
 Drivers License No.  
 Method of Payment: Insurance Cash Credit Card

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Purpose of Call

I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.

Other Family Members in Practice

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Whom may we thank for this referral?

I understand that my dental care insurance or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts.

Someone to notify in case of emergency not living with you

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in party by my dental care payor.

I attest to the accuracy of the information on this page.

\_\_\_\_\_  
 Signature Date



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## Dental History

**Please answer the following questions**

Purpose of initial visit			
Are you aware of a problem? Explain.	YES	NO	
How long since your last dental visit?			
What was done at that time?			
Previous dentist's name			
Address:			Tel:
When was the last time your teeth were cleaned?			
Have you made regular visits?	YES	NO	
How often:			
Were dental x-rays taken?	YES	NO	
Have you lost any teeth or have any teeth been removed?	YES	NO	
Why?			
How have they been replaced?			
Fixed bridge			Age:
Removable bridge			Age:
Denture			Age:
Are you happy with the replacement?	YES	NO	
If yes, Explain:			
Would you like to know about permanent replacements?	YES	NO	
Have you ever had any problems or complications with previous dental treatment?	YES	NO	
If yes, Explain:			
Do you clench or grind your teeth?	YES	NO	
Do you clench or grind your teeth?	YES	NO	
Does your jaw click or pop?	YES	NO	
Have you experienced any pain or soreness in the muscles of your face or around your ear?	YES	NO	
Do you have frequent headaches, neckaches or shoulder aches?	YES	NO	
Does food get caught in your teeth?	YES	NO	
Are any of your teeth sensitive to:      Hot:      Cold:      Sweets:      Pressure:			
Do your gums bleed or hurt?	YES	NO	
When?			
How often do you brush your teeth?			
When?			
Do you use dental floss?	YES	NO	
How often			
Are any of your teeth loose, tipped, shifted or chipped?	YES	NO	
Are you unhappy with the appearance of your teeth?	YES	NO	
How do you feel about your teeth in general?			
Do you feel your breath is offensive at times?	YES	NO	
Have you ever had gum treatment or surgery?	YES	NO	
What?			
Where?			
When?			
Have you had any orthodontic work?	YES	NO	
Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike?	YES	NO	
Do you have any questions or concerns?	YES	NO	
If yes, Explain:			

Comments

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

Patient's Signature \_\_\_\_\_  
 Dentist's Signature \_\_\_\_\_

Date \_\_\_\_\_  
 Date \_\_\_\_\_