

*WELCOME*  
*MOSTOFI DENTAL CORPORATION*  
*General, Cosmetic, and Implant Dentistry*

PATIENT INFORMATION

DENTAL INSURANCE

Date: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Name: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

Subscriber's Relationship to Patient: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

Group No.: \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_

Any Additional Insurance?: \_\_\_ Yes \_\_\_ No

Telephone: Cell (\_\_\_\_) \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Telephone: Work (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Group No.: \_\_\_\_\_



E-mail: \_\_\_\_\_

Sex: \_\_\_F \_\_\_M Date of Birth: \_\_\_\_\_

Social Security No.: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Contact Tel: (\_\_\_\_) \_\_\_\_\_

How were you referred to us?

Friend or Family (please specify): \_\_\_\_\_

Internet (please specify): \_\_\_\_\_

News/Mag (please specify): \_\_\_\_\_

Other (please specify): \_\_\_\_\_

**ASSIGNMENT & RELEASE**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. Mostofi all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Print Name-Patient, Parent/Guardian, or Representative

\_\_\_\_\_  
Signature-Patient, Parent/Guardian, or Representative

# WELCOME

## MOSTOFI DENTAL CORPORATION

*General, Cosmetic, and Implant Dentistry*

### DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_  
 Date of last dental visit: \_\_\_\_\_  
 Date of last dental x-rays: \_\_\_\_\_

- Bad breath  Yes  No
- Bleeding gums  Yes  No
- Blisters on lips or mouth  Yes  No
- Burning sensation on tongue  Yes  No
- Chew on one side of mouth  Yes  No
- Cigarette, pipe, or cigar smoking  Yes  No
- Clicking or popping jaw  Yes  No
- Dry mouth  Yes  No
- Fingernail biting  Yes  No
- Grinding teeth  Yes  No
- Gums swollen or tender  Yes  No

### DENTAL HISTORY CONTINUED

- Do you like the appearance of your teeth, your smile?  Yes  No
- Are your teeth all straight?  Yes  No
- Do you have spaces between your teeth that you do not like?  Yes  No
- Do you like the color of your teeth?  Yes  No
- Do you like the shape of your teeth?  Yes  No
- Are your teeth chipped, protruding, and/or hidden?  Yes  No



- Jaw pain or tiredness  Yes  No
- Lip or check biting  Yes  No
- Loose teeth or broken fillings  Yes  No
- Mouth breathing  Yes  No
- Mouth pain, brushing  Yes  No
- Orthodontic treatment  Yes  No
- Pain around ear  Yes  No
- Periodontal treatment  Yes  No
- Sensitivity to cold  Yes  No
- Sensitivity to heat  Yes  No
- Sensitivity to sweets  Yes  No
- Sensitivity when biting  Yes  No
- Food collection between teeth  Yes  No
- Sores or growths in your mouth  Yes  No
- How often do you floss? \_\_\_\_\_
- How often do you brush? \_\_\_\_\_

- Do you like the way your teeth come together?  Yes  No
- Are there old fillings/dental work that you do not like the look of?  Yes  No
- What would you like to change about the appearance of your teeth? \_\_\_\_\_
- How would you like your teeth to look? \_\_\_\_\_
- Medications (please list any medications you are currently taking): \_\_\_\_\_
- Allergies (please list anything, including medications, that you are or may be allergic to): \_\_\_\_\_

# WELCOME

## MOSTOFI DENTAL CORPORATION

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### HEALTH HISTORY

Physician's Name: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Have you ever taken any of the groups of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)

Yes  No

- AIDS/HIV  Yes  No
- Anemia  Yes  No
- Arthritis, Rheumatism  Yes  No
- Artificial heart valves  Yes  No
- Artificial joints  Yes  No
- Asthma  Yes  No

### HEALTH HISTORY CONTINUED

- Heart murmur  Yes  No
- Heart problems  Yes  No
- Hepatitis Type \_\_\_\_\_  Yes  No
- Herpes  Yes  No
- High blood pressure  Yes  No
- Jaundice  Yes  No
- Jaw pain  Yes  No
- Kidney disease  Yes  No
- Liver disease  Yes  No
- Low blood pressure  Yes  No
- Mitral valve prolapse  Yes  No
- Nervous problems  Yes  No
- Pacemaker  Yes  No
- Psychiatric care  Yes  No
- Radiation treatment  Yes  No



- Back problems  Yes  No
- Bleeding abnormally with extractions or surgery  Yes  No
- Blood disease  Yes  No
- Cancer  Yes  No
- Chemical dependency  Yes  No
- Chemotherapy  Yes  No
- Circulatory problems  Yes  No
- Congenital heart lesions  Yes  No
- Cortisone treatments  Yes  No
- Cough, persistent or bloody  Yes  No
- Diabetes  Yes  No
- Emphysema  Yes  No
- Epilepsy  Yes  No
- Fainting or dizziness  Yes  No
- Glaucoma  Yes  No
- Headaches  Yes  No

- Respiratory disease  Yes  No
- Rheumatic fever  Yes  No
- Scarlet fever  Yes  No
- Shortness of breath  Yes  No
- Sinus trouble  Yes  No
- Skin rash  Yes  No
- Special diet  Yes  No
- Stroke  Yes  No
- Swollen feet or ankles  Yes  No
- Swollen neck glands  Yes  No
- Thyroid problems  Yes  No
- Tonsillitis  Yes  No
- Tuberculosis  Yes  No
- Tumor or growth on head or neck  Yes  No
- Ulcer  Yes  No
- Venereal disease  Yes  No
- Weight loss, unexplained  Yes  No