Safaeddin Jahanbani, D.D.S Inc.
949 502 5100

GREEN DENTAL
FAMILY DENTISTRY

# DENTAL REGISTRATION AND HISTORY

## 1. Patient Information

**Date** _____

| |
|---|
| Name: Last _____ First _____ Middle _____ |
| Birth Date: Patient ID/SS#: |
| Sex: M ___ F___ Married ___ Widowed ___ Single ___ Minor ___ |
| Address: |
| City: State: Zip Code: |
| Occupation: Employer/School: |
| Phone Numbers: Home _____ Work _____ Cell Phone _____ |

**IN CASE OF EMERGENCY, CONTACT** (someone who does not live in your household)
Name: _____Relationship _____ Phone #: _____

**Whom may we thank for referring you?** _____

## 2. Dental Insurance

Subscriber's Name: _____
Birth Date: _____ SS# _____ Relationship to you: _____
Insurance Co. _____ Group #: _____

**ASSIGNMENT AND RELEASE**

I certify that I, and/or my dependent(s) have insurance coverage with _____;and assign directly to Dr. Safaeddin Jahanbani /Green Dental 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 Dentist 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

**Signature of Patient, Parent or Guardian** _____ Date: _____

## 4. Dental History

Reason for today's visit: _____

Former Dentist: _____Phone #: _____

Date of last dental visit: _____ Date of last dental X-rays:_____

Please continue on the back

## 4. Health History Questioner

**Your Physician's name:** _____ **Phone #:** _____

**PLACE A MARK ON YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | ____ | ____ | Fainting/Dizziness | ____ | ____ | Pins/Rods/screws | ____ | ____ |
| Anemia | ____ | ____ | Glaucoma | ____ | ____ | Psychiatric Care | ____ | ____ |
| Arthritis/Rheumatism | ____ | ____ | Headaches | ____ | ____ | Radiation Treatment | ____ | ____ |
| Artificial Heart Valve | ____ | ____ | Hearing Loss | ____ | ____ | Respiratory Disease | ____ | ____ |
| Artificial Joints | ____ | ____ | Heart Murmur | ____ | ____ | Rheumatic Fever | ____ | ____ |
| Asthma | ____ | ____ | Are you in good Health? | ____ | ____ | Scarlet Fever | ____ | ____ |
| Back Problems | ____ | ____ | Heart Defect from Birth | ____ | ____ | Schizophrenia | ____ | ____ |
| Bleeding Abnormally | ____ | ____ | Heart Problems | ____ | ____ | Shortness of Breath | ____ | ____ |
| Blood Disease | ____ | ____ | Hemophilia | ____ | ____ | Shunts | ____ | ____ |
| Blood Transfusion | ____ | ____ | Hepatitis Type____ | ____ | ____ | Skin Rash | ____ | ____ |
| Cancer | ____ | ____ | Herpes | ____ | ____ | Skin Trouble | ____ | ____ |
| Cerebral Palsy | ____ | ____ | High Blood Pressure | ____ | ____ | Special Diet | ____ | ____ |
| Chemical Dependency | ____ | ____ | Implants | ____ | ____ | Speech Impairment | ____ | ____ |
| Chemotherapy | ____ | ____ | Jaundice | ____ | ____ | Stroke | ____ | ____ |
| Chest Pain/Angina | ____ | ____ | Jaw Pain | ____ | ____ | Swollen Feet/Ankles | ____ | ____ |
| Circulatory Problems | ____ | ____ | Kidney Disease | ____ | ____ | Swollen Neck Glands | ____ | ____ |
| Congenital Heart Lesions | ____ | ____ | Learning Disability | ____ | ____ | Thyroid Problems | ____ | ____ |
| Cortisone Treatments | ____ | ____ | Low Blood Pressure | ____ | ____ | Tonsillitis | ____ | ____ |
| Cough persistent or Bloody | ____ | ____ | Lung Disease | ____ | ____ | Tuberculosis | ____ | ____ |
| Diabetes | ____ | ____ | Lupus | ____ | ____ | Tumor Head/Neck | ____ | ____ |
| Down's syndrome | ____ | ____ | Mitral Valve Prolapse | ____ | ____ | Ulcer | ____ | ____ |
| Emphysema | ____ | ____ | Nervous Problems | ____ | ____ | Venereal Disease | ____ | ____ |
| Epilepsy | ____ | ____ | Pacemaker | ____ | ____ | Unexplained Weight Loss | ____ | ____ |

Any other Health condition not listed above? _____

Do you smoke? No___ Yes___ How much? _____ . Do you drink? No ___. Yes ___. How much? _____.

Have you ever taken any of the groups of drugs collectively referred to as "Fen-Phen"? These include combinations of Lonimin, Adipex, Fastin, Pondimin and Redux, (all brand names of Phentermine or Fenfluramine), Yes____ No ____

Have you ever been hospitalized? No____ Yes____ (Please explain) _____
Have you had any surgeries? No____ Yes____ (Please explain) _____
**Women:** Are you Pregnant? No____ Yes____ (Due date _____) Are you nursing? Yes____ No____
Are you using birth control medication? No____ Yes____ (what kind? _____)

## MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:
_____
_____

Pharmacy Name: _____Phone#: _____

## ALLERGIES

Aspirin ☐ Local Anesthetic ☐
Barbiturates (sleeping pills) ☐ Sulfa ☐
Codeine ☐ Latex ☐

Iodine ☐ penicillin ☐
Other: _____

Patient or Parent/Guardian Signature: _____ Date: _____

_____ Date: _____

_____ Date _____

Doctor's Signature: _____Date: _____