



John Rezaei, DMD

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NEW PATIENT FORM

PATIENT INFORMATION

Full Name: _____ Date of Birth: _____

SSN: _____ Gender: Male Female Other

Address: _____ City: _____

State: _____ Zip: _____

Email: _____

Cell Phone: _____ Text Messages? **Y** or **N**

Home Phone: _____

Work Phone: _____

Marital Status: Single Married

Emergency Contact: _____

Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Subscriber Name: _____

Subscriber DOB: _____ Subscriber DOB: _____

Member ID: _____ Member ID: _____

Group #: _____ Group #: _____

MEDICAL HISTORY

Are you under a physician's care? Yes No

If yes, explain: _____

Physician Name: _____ Phone: _____

Are you taking medication? Yes No

List medications: _____

Do you have allergies? Yes No

Penicillin Latex Anesthesia Other: _____

Have you had any of the following? (Check all that apply)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | |

Are you pregnant? Yes No N/A

DENTAL HISTORY

Reason for today's visit: _____

Date of last dental visit: _____

Do you experience: Bleeding gums Grinding/Clenching
 Jaw pain Frequent headaches
 Tooth sensitivity Other: _____

AUTHORIZATION & AGREEMENT

I certify that the information provided is true and complete. I authorize Vivid Dental to release information necessary to process insurance claims and assign benefits directly to the office. I understand that I am financially responsible for all charges.

Signature: _____ Date: _____