Date: _____

ADDITIONAL CONTACT INFORMATION

CELL _____

E-MAIL _____

LAJOLLA DENTAL IMAGE

WALI HAMIDY, D.M.D.
4150 REGENTS PARK ROW, SUITE 200
LA JOLLA CA 92037

PATIENT INFORMATION

Patient Name _____ SSI# _____
First Name Last Name

Address _____ Driver's Lic. # _____

City _____ State _____ Zip _____ Home Phone _____

Sex ☐ M ☐ F Birthdate _____ Age _____ Marital Status _____

Patient Employer _____ Occupation _____

Have any members of your family been to our office? _____

How were you referred? ☐ Patient referral Whom may we thank? _____

☐ Internet ☐ Health Fair ☐ Insurance ☐ Letter/flyer in the mail ☐ Saw building/sign ☐ Dental Referral Service

☐ Advertisement (which?) _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Phone _____

Date of last dental care _____ Date of last dental x-rays _____

Check ☑ if you have had problems with any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Clicking or popping of jaw	☐	☐	Grinding teeth	☐	☐	Sensitivity to hot and cold
☐	☐	Food collection between teeth	☐	☐	Periodontal treatment	☐	☐	Sensitivity to sweets
☐	☐	Loose teeth or broken fillings	☐	☐	Sores or growth in mouth	☐	☐	Sensitivity when biting

Do you wear dentures or partial dentures? _____ If so, when were they made? _____

Is there any other information we should know about any other dental visits? _____

PHARMACY INFORMATION

Pharmacy Name _____

Address _____

Phone _____

Patient Name: _____

PRIMARY INSURANCE

Person Responsible for Account _____

Relationship to Patient _____

Address (if different from patient's) _____

City _____ State _____ Zip _____

Person Responsible Employer _____

Business Address _____ Bus. Phone _____

Insurance Company _____

Group # _____ SS# _____ Contract # _____

Names of other dependents covered under this plan _____

SECONDARY INSURANCE

Is patient covered by additional insurance? ☐ YES ☐ NO Insurance Company _____

Subscriber Name _____ Relationship to patient _____ Birthdate _____

Address (if different from patient's) _____

City _____ State _____ Zip _____ SS# _____

Subscriber Employed by _____ Bus. Phone _____

Group # _____ Subscriber # _____ Contract # _____

Names of other dependents covered under this plan _____