Dental & Health History
Dr. Parisa Sepehri

Your overall health as well as any medications, which you take, could have an important interrelationship with the dental care you receive. Please answer each of the following questions completely.

Name _____ **Sex** _____ **Birth date** _____

Primary Care Doctor _____ **Dr. Phone #** _____
First Name **Last Name**

Dr's Address: _____
City _____ **Zip** _____

Previous hospitalizations/surgery/serious illnesses? _____
_____

Have you ever taken the medication *Fosamax*? Y / N

Are you currently taking any medication? Please list medication and purpose.

Medication	Purpose	Medication	Purpose
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

Do you have a history of allergies/sensitivities/adverse reactions to any drugs or medications? Y / N
If yes please describe.
_____

_____

Do you have allergies to latex or other substances?

_____

DO YOU HAVE OR HAVE YOU HAD IN THE PAST:

YES	NO		YES	NO	
___	___	Asthma	___	___	Handicaps/disabilities
___	___	Cancer	___	___	Tuberculosis
___	___	Hepatitis	___	___	Diabetes
___	___	HIV/AIDS	___	___	Kidney Disease
___	___	Abnormal Bleeding	___	___	Liver Disease
___	___	Blood Disease	___	___	Arthritis
___	___	Anemia	___	___	Epilepsy/Seizures
___	___	High Blood Pressure	___	___	Fainting/Dizziness
___	___	Stroke	___	___	Heart Murmur
___	___	Rheumatic Fever	___	___	Congenital Heart Defect
___	___	Ear Problems	___	___	Congestive Heart Failure
___	___	Headaches	___	___	Other: _____
___	___	Are you/or are you trying to become pregnant?	___	___	Radiation Therapy
___	___	Do you take birth control medication?	___	___	Allergies
___	___	Recreational or street drugs	___	___	Psychiatric Treatment

___ ___ Do you have a family history of diseases? If so please explain: _____

_____

Previous dentist _____ date of last visit _____

How often do you brush? _____ How often do you floss? _____

Do you have any dental concerns or problems? _____

AUTHORIZATION & RELEASE
To the best of my knowledge the questions on this form have been accurately answered. I authorize the Dentist to release any information of my dental treatment and diagnosis to my insurance company. I also authorize and request my insurance company to pay directly to the Dentist benefits otherwise payable to me.

_____
Signature of patient or parent if minor Date