ASIRI FAMILY DENTISTRY
8000 McBeth Way, #145, The Woodlands, TX 77382
asirifamilydentistry.com

PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we are happy to help you.

PERSONAL

Name ____
Last First MI (Preferred)

Birthdate________________________SS#_______________________________Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Work Phone__________________________Wireless Phone________________________Home Phone ________________________

Email____

Preferred Contact Method [ ] Hm Phone [ ] Wk Phone [ ] Wireless Ph [ ] Email

Student status if dependent over 19 (for ins) [ ] Non student [ ] Fulltime [ ] Part-time

General Dentist____Office Phone ____

How did you hear about us?____

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS

Check box if same for entire family [ ]

Address____

City______________________________State__________Zip ________________________

INSURANCE POLICY 1

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other _______________________

Subscriber Name____Subscriber ID # ________________________________

Insurance Company____Phone_______________________________________

Employer_________________________________Group Name__________________________Group # __________________

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child [ ] Other _______________________

Subscriber Name____Subscriber ID # __________________________________

Insurance Company____Phone____________________________________

Employer__________________________________Group Name___________________________Group # ___________________

MEDICAL HISTORY

Name of Medical Doctor:____Office Phone: ______________________________

Date of Last Physical Exam:_________________________Height:______________Weight: ____________

Emergency Contact_______________________________Phone__________________________Relationship__________________

List all medications that you are now taking:

________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________
________________________________ ________________________________ ________________________________

Have you had abnormal bleeding with previous extractions, surgery, or trauma? [ ] Y [ ] N
Have you ever required a blood transfusion? [ ] Y [ ] N
Have you ever had radiation for any condition? [ ] Y [ ] N
Have you ever tested positive for HIV infection or AIDS? [ ] Y [ ] N
If so, please state date diagnosed and treating doctor.________________________________
Are you required to take antibiotics prior to dental treatment? [ ] Y [ ] N
Are you allergic to any of the following?

[ ] Anesthetic [ ] Ibuprofen [ ] Penicillin
[ ] Aspirin [ ] Iodine [ ] Sulfa
[ ] Codeine [ ] Latex [ ] Other ______________

Do you have or have you had any of the following medical conditions?

[ ] Asthma	[ ] Delay in healing	[ ] Hepatitis, jaundice	[ ]Psychiatric Treatment
[ ] Arthritis	[ ] Diabetes	[ ] High Blood Pressure	[ ][Rheumatic Fever
[ ] Bleeding problems	[ ] Emphysema	[ ] Infectious Mononucleosis	[ ][Sinus trouble
[ ] Blood disorder	[ ] Fainting spells or seizures	[ ] Joint prosthesis	[ ][Stroke
[ ] Bruise easily	[ ] Glaucoma or eye disease	[ ] Kidney disease	[ ][Tuberculosis
[ ] Cancer	[ ] Gallbladder trouble	[ ] Liver Disease	[ ][Ulcers, colitis
[ ] Cardiac Pacemaker	[ ] Heart disease	[ ] Low Blood Pressure	[ ][Venereal Disease
[ ] Chest pain, angina	[ ] heart Murmur	[ ]On a diet	[ ] Wear contact lenses

Are you taking any herbal medicine (i.e., St. John's Wort)? [ ] Y [ ] N
Have you ever taken the "fen-phen" diet pill? [ ] Y [ ] N
Do you have any disease, condition or problem not listed above? [ ] Y [ ] N
Specify.____
Are you takin bisphosphonates now or have you taken them in the past (Fosamax)? [ ] Y [ ] N
Do you currently have or have you had a history of alcohol or drug abuse? [ ] Y [ ] N
Tobacco use? If so, what kind and how often? ________________________________
Unusual reaction to dental injections? ____________________________________

WOMEN ONLY:

Possibility of pregnancy? [ ] Y [ ] N If yes, estimated delivery date. ________________
Nursing? [ ] Y [ ] N
Taking birth control pills? [ ] Y [ ] N
Note: Anitibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

Please note the reason for your visit:______________________________________Are you in pain? [ ] Y [ ] N

By signing below, you agree you have answered all questions honestly and to the best of your knowledge.

______________________________ ____________________
Print Patient Name Date

____
Patient/Guardian Signature