Date ______________

Welcome to Paparian Dental Associates

Seth C. Paparian, D.M.D

PATIENT INFORMATION

Name ____ Sex M / F
Last First MI

DOB ______________ Age_______ SSN __________________

Address__________________________ Apt.____ City _______________ State ____ Zip _______

Home phone ________________ Work ______________ Ext ____ Cell _____________

Email _____________________ Would you like to receive appointment reminders via email? Y / N

Circle: Single Married Divorced Widowed Partnered Minor

Full Time Student Y / N If yes, College, City, State ____________________________________

Employer _________________________ Occupation ____________________________

Emergency Contact person ____________________ Phone # ______________ Relation: ____________

Whom may we thank for referring you to our office? _____________________________

DENTAL INSURANCE

(Please bring your card or form as we will need a copy)

Policy Holder __________________________ Relationship to Patient _______________

DOB _______________ SSN _________________ Employer _____________________

Insurance Company _________________________________

DENTAL HISTORY

(A copy of recent x-rays would be very helpful to have at your first visit- bring them with you or have them sent to our office ahead of time)

Previous Dentist _______________________ Address ___________________________

Last visit ___________ Date of last x-rays __________ Date of last cleaning _________

How often do you brush? ____________ Floss? __________

DENTAL HISTORY

Do your gums bleed easily?	Y / N	Do you wear a partial/denture?	Y / N
Are your teeth sensitive to Hot, cold, or sweets	Y / N	Do you smoke/use tobacco?	Y / N
Do you have pain in any of your teeth?	Y / N	Do you clench or grind your teeth?	Y / N
Have you had prolonged Bleeding after extractions?	Y / N	Have you ever had:	
Have you had orthodontics?	Y / N	Jaw clicking	Y / N
		Jaw pain	Y / N
		Difficulty opening	Y / N
		Do you like your smile?	Y / N

HEALTH HISTORY

Primary Care Physician ____________________ Phone Number ________________ Date of Last Exam ______

AIDS/HIV	Y / N	Headaches	Y / N	Scarlet Fever	Y / N
Anemia	Y / N	Heart Murmur**	Y / N	Shortness of Breath	Y / N
Arthritis/Rheumatism	Y / N	Heart Problems	Y / N	Sinus Trouble	Y / N
Artificial Heart Valve	Y / N	Hepatitis Type ___	Y / N	Skin Rash	Y / N
Asthma	Y / N	Herpes	Y / N	Special Diet	Y / N
Blood Disease	Y / N	High Blood Pressure	Y / N	Stroke	Y / N
Cancer	Y / N	Jaundice	Y / N	Swollen Feet or Ankles	Y / N
Chemotherapy	Y / N	Joint Replacement**	Y / N	Swollen Neck Glands	Y / N
Circulatory Problems	Y / N	Kidney Disease	Y / N	Thyroid Problems	Y / N
Congenital Heart Lesions	Y / N	Liver Disease	Y / N	Tonsillitis	Y / N
Cortisone Treatments	Y / N	Low Blood Pressure	Y / N	Tuberculosis	Y / N
Cough, persistent or bloody	Y / N	Mitral Valve Prolapse**	Y / N	Tumor/Growth on head or neck	Y / N
Diabetes	Y / N	Nervous Problems	Y / N	Ulcer	Y / N
Emphysema	Y / N	Pacemaker	Y / N	Weight Loss unexplained	Y / N
Epilepsy	Y / N	Radiation Treatment	Y / N	Other ____________	Y / N
Fainting/Dizziness	Y / N	Respiratory Disease	Y / N		
Glaucoma	Y / N	Rheumatic Fever	Y / N		

** If you answered yes to any of these 3 conditions, do you need to pre-medicate prior to dental visits? Y / N
If yes, name of medication and dosage: ____________________________

WOMEN ONLY:
Are you pregnant? Y / N / Not Sure Due Date __________ Nursing Y / N
Taking Birth Control Pills Y / N

ALLERGIES

Aspirin	Y / N	Penicillin	Y / N
Codeine	Y / N	Sulfa	Y / N
Latex	Y / N	Other ____________	Y / N
Local Anesthetics	Y / N		
Metals	Y / N		

MEDICATIONS

Please list all current prescription & over the counter medications (If more than 3 please provide a list)

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____

Signature: ______________________________________ Date: _____________________