HIGHLAND CREEK DENTAL
DR. SARA RAZMAVAR

Name*: Last: _____ First: _____ Preferred: _____

E-Mail*: _____ to receive email confirmations, updates and newsletters

Address: _____

Home Phone: (____) _____-_____ Cell Phone*: (_____): _____-_____

Employer: _____ Work Phone: (_____) _____ -_____ X _____

Date of Birth: (D/M/Yr) _____

Emergency Contact: Name: _____ Relationship: _____

Emergency Phone: (____) _____-_____

Notes (specific contact information or preferences): _____

_____

* ***These are required fields. They must be filled out***

Which method is the best and most reliable way to get in touch with you? Please circle the one you are sure to get the message promptly and note if there are specific times and days:

HOME PHONE ☐ WORK PHONE ☐ CELL PHONE ☐ TEXT MESSAGE ☐ EMAIL ☐

Notes (specific time or days or …): _____

How did you hear about us? Please click box next to your choice:

Google ☐ Website ☐ Signage ☐ Print Advertisement ☐ Business Listings: Digital ☐ Print ☐

Social Media : Facebook ☐ Instagram ☐ Twitter ☐

Other/Referral, Please Name: _____

Primary Insurance:

Name of Policy Holder: _____ Insurance Company:_____

D.O.B (D/M/Yr): _____ Plan #: _____ Member ID #: _____

Secondary Insurance:

Name of Policy Holder: _____ Insurance Company: _____

Relationship: _____

D.O.B (D/M/Yr): _____ Plan #: _____ Member ID #: _____

MEDICAL HISTORY:

Are you currently being treated for any Medical Conditions. If yes, please provide details:

_____

Are you taking any Medications or Non-Prescription Drugs. If yes, please list all:

_____

Do you require any Medications or Antibiotics before Dental Treatment? Y☐ N☐

Allergies (Food, Medicine/Latex/Penicillin/Anesthesia or Other) _____

Physician /Specialist Name: _____ **Date of last Visit:** _____

Have you ever been seriously ill or had any Major Surgery? If yes, please provide details:

_____

Do you bleed excessively?	Y☐ N☐	**Have you ever Fainted?**	Y☐ N☐
Have you had Chest Pain?	Y☐ N☐	**Have you had Heart Problems?**	Y☐ N☐
Do you have Asthma ?	Y☐ N☐	**Do you have AIDS?**	Y☐ N☐
Do you have Hepatitis?	Y☐ N☐	**Are you HIV Positive?**	Y☐ N☐

Have you ever had or are receiving Chemo Or Radiation Therapy? Y☐ N☐

How can we help you today? Specific Concerns or Comprehensive Care / New Patient Exam?

_____

Is there anything we can do to make your appointment more comfortable or convenient for you?

_____

Patient information will be kept confidential accept as is necessary to provide services or to insure that all administrative matters related to your care are handled appropriately. All information is kept strictly confidential in accordance with privacy regulations.

I understand that the information that I have provided is correct and to the best of my knowledge and that it is my full responsibility to inform this office of any changes. I also consent to examination and treatment as advised by the Doctor. Payments are due when services are rendered.

Please email completed form to info@highlandcreekdental.ca when completed

Signature*: _____ Date: _____