HIGHLAND CREEK DENTAL
DR. SARA RAZMAVAR

Patient Registration From

Note: information marked with star (*) are mandatory and must be filled out.

Personal Information

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

Title: ☐ Dr /☐ Mr /☐ Mrs /☐ Ms / ☐ Other: _____ **Date of Birth * : Day** _____ **Month** _____ **Year** _____

Address * : _____ **City * :** _____ **Postal Code * :**_____

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

Occupation * : _____ **Work Phone: (**_____**)** _____ -_____ **X** _____

E-Mail * : _____ ☐ **I consent to receive appointment notifications and newsletters**

Which one of below methods is the quickest and most reliable way to get in touch with you?

☐ HOME PHONE / ☐ WORK PHONE / ☐ CELL PHONE / ☐ TEXT MESSAGE / ☐ E-MAIL / ☐ OTHER : _____

Notes (specific time of the day or any consideration): _____

Emergency Info

Emergency Contact: Full Name * : _____ Relationship : _____

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

Notes (specific contact instructions or preferences): _____

Family Physician: Full Name: _____ Office Phone: (____) _____-_____

Specialist: For: _____ Full Name: _____ Office Phone: (____) _____-_____

Visit Information

How can we help you?

☐ Comprehensive Exam ☐ Dental Hygiene/Cleaning

☐ Pain Relief/ Emergency ☐ Other:_____

How did you hear about us?

Referral: Name of Referee: _____ Social Media : ☐ Facebook / ☐ Instagram

☐ Google / ☐ Website / ☐ Signage / ☐ Flyers / ☐ Newspaper/ ☐ Magazine / ☐ Other: _____

Dental Insurance Information

Primary Insurance:

Insured Name: First:_____ Last:_____ Insured Date of Birth: D ___ M _____ Y _____

Insured Employer: _____ Insurance Company: _____

Plan or Group : _____ Certificate/Member ID #: _____

Secondary Insurance (if available):

Insured Name: First:_____ Last:_____ Insured Date of Birth: D ___ M _____ Y _____

Insured Employer: _____ Insurance Company: _____

Plan or Group : _____ Certificate/Member ID #: _____

Relationship to Insured: _____ Insured Cell Phone: (_____) _____-_____

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Medical History and Information

When was your last Dental visit? * _____ When was your last Medical check-up? * _____

Do you have tendency to bruise easily or bleed for a prolonged period of time? * ☐ **YES / ☐ NO**

Have you ever had or are receiving Chemo or Radiation Therapy? * ☐ **YES / ☐ NO**

Do you require any Medications or Antibiotics before Dental Treatment? * ☐ **YES / ☐ NO**

If yes, please provide details: _____

Are you currently being treated for any Medical conditions? Are you currently being required to self-isolate? * ☐ **YES / ☐ NO**

If yes, please provide details: _____

Are you taking any Medications (including blood thinners) or Non-Prescription Drugs? * ☐ **YES / ☐ NO**

If yes, please list all: _____

Has there been any changes in your general health recently? Have you gained or lost excessive weight? * ☐ **YES / ☐ NO**

If yes, please provide details: _____

Have you ever been seriously ill, hospitalized or had any major surgery? * ☐ **YES / ☐ NO**

If yes, please provide details: _____

Have you ever had a peculiar or adverse reaction to any Medication, Injection or Anesthesia? * ☐ **YES / ☐ NO**

If yes, please list all: _____

Do you have allergies or sensitivities to any Food or Material (including Latex)? * ☐ **YES / ☐ NO**

If yes, please list all: _____

Do you have or ever had the following * :

☐ Chest Pain/Angina	☐ Shortness of Breath	☐ Nausea	☐ Fainted

Do you have or ever had the following * :

☐ AIDS/ HIV Positive	☐ Hepatitis	☐ Tuberculosis	☐ Asthma
☐ Heart Attack/Condition	☐ High Blood Pressure	☐ Heart Murmur	☐ Pacemaker
☐ Mitral Valve Prolapse	☐ Rheumatic Fever	☐ Sinusitis	☐ Bronchitis
☐ Stomach Ulcer	☐ Liver Disease	☐ Kidney Disease	☐ Diabetes
☐ Psychiatric disorders	☐ Drug/Alcohol dependency	☐ Smoke/Vape heavily	☐ Arthritis

Do you have or ever had the following * :

☐ Teeth Grinding/Clenching	☐ Pain/Tenderness in Jaw	☐ Bleeding Gum	☐ Bad Breath

For woman only * :

☐ Take birth control pills	☐ Pregnant (Due Date: _____)	☐ Breast Feeding	☐ Special Care

Patient Consent

☐ I understand that all my information will be kept strictly confidential in accordance with privacy regulations; and, I authorize release as is necessary to provide proper and safe services.

☐ I consent the Dentist and auxiliary staff to perform necessary examination, diagnostic procedures and treatment, as required, to achieve the proper level of dental care.

☐ I acknowledge that I would be financially responsible for the Dental services provided regardless of insurance coverage; and, I understand payments are due when services are rendered.

☐ I understand that the appointment time given to me is reserved for me only; and as a courtesy to time and dedication of Dentist and auxiliary staff, it is my responsibility to inform the office if I need to change or cancel at least 2-business-day before my appointment. I acknowledge that if I fail to do so, I would be responsible to pay no-show or short-notice cancelation fee with no exception other than for extreme emergencies.

☐ I certify that I have read, understood and accurately completed this form to the best of my knowledge and have not knowingly omitted any information. I also acknowledge that it is my full responsibility to inform the office of any changes prior to my upcoming appointment and fill the "Patient Update Form" once in the office.

Full Name*: _____ **Signature*:** _____ **Date*:** _____