MARYAM M. MONFARED D.D.S. **ENDODONTICS**
3801 N. FAIRFAX DR., SUITE 51 N., ARLINGTON, VIRGINIA 22203 TEL. (703) 528-4384

Welcome to our office . . .

PERSONAL INFORMATION

Name: Mr / Mrs / Miss / Ms / Dr_____ SSN_____-____- _____

Required By Insurance Co. Single Married

Spouse or Parent (If child): _____ SSN_____-_____-_____

Home Address (No P.O. Box)_____

City_____ State _____Zip_____

Home Tel. _____Work Tel._____Cell._____

Email: _____

Employer_____ Occupation_____

Date of Birth_____Person Responsible for Payment Account_____

Whom May We Thank for Referring You?_____Name of General Dentist_____

Pharmacy Tel. and Address. _____ _____

Emergency Contact and Tel. _____

EMPLOYER AND DENTAL INSURANCE INFORMATION

Insurance Company Name, Address, Phone No._____

_____ ID #: _____

Group #_____Relationship to Policy Holder (Self, Spouse, Child)_____

Policy Holder's Name: _____Policy Holder's SSN_____-_____-_____

Policy Holder's Birth Date_____Policy Holder's Employer_____

Employer's Address and Tel#_____

Secondary Insurance Co. Name_____Group #_____

FINANCIALLY RESPONSIBLE PERSON

(If other than patient)

Name: _____Relationship to patient:_____

Address: _____

Home Tel: _____Work Tel: _____

Date of Birth: _____Soc. Sec. No: _____-_____-_____

DENTAL HISTORY
Reason for Today's Visit? _____

Do you currently have problems with any of the following?

◊ Bad breath	◊ Grinding teeth or clenching teeth	◊ Sensitive to hot
◊ Bleeding	◊ Oral sores or growths	◊ Sensitive to sweets
◊ Clicking or popping	◊ Periodontal treatment	◊ Sensitive when biting
◊ Food collection between teeth	◊ Sensitive to cold	◊ Spontaneous pain

MEDICAL HISTORY
Primary Physician's name _____Date of last visit_____
Have you had any serious illnesses or been hospitalized in the past two years? ◊ Yes ◊ No
If yes, please describe_____
_____

(Women Only) Are you pregnant? ◊ Yes ◊ No If Yes, what month?___ Nursing? ◊ Yes ◊ No
Taking birth control pills? ◊ Yes ◊ No

Are you **allergic** or had an adverse reaction to any of the following medications or substances?

Aspirin	Demerol	Nitrous Oxide	Tetracycline
Clindamycin	Erythromycin	Ibuprofen	Tylenol
Codeine	Latex	Penicillin	Vicodin
Darvon	Local Anesthetic	Percocet	Other

If other, please list: _____

If you have or have had any of the following, Please check:

◊ Anemia	◊ Circulatory Problems	◊ High Blood Pressure	◊ Scarlet Fever
◊ Arthritis, Rheumatism	◊ Cough, Persistent	◊ HIV Positive	◊ Shortness of Breath
◊ Artificial Heart valve	◊ Cough up Blood	◊ Hepatitis	◊ Skin Rash
◊ Artificial Joints	◊ Diabetes	◊ Kidney Disease	◊ Stroke
◊ Asthma	◊ Epilepsy	◊ Liver Disease	◊ Swelling of feet or ankles
◊ Back Problems	◊ Fainting	◊ Mitral Valve Prolapse	◊ Thyroid Disorder
◊ Blood Disease	◊ Glaucoma	◊ Neurological Disease	◊ Tobacco Habit
◊ Blood Transfusion	◊ Headaches	◊ Pacemaker	◊ Tonsillitis
◊ Cancer	◊ Heart Murmur	◊ Rheumatic fever	◊ Tuberculosis
◊ Chemical Dependency	◊ Heart Disease	◊ Radiation Treatment	◊ Ulcer
◊ Chemotherapy	◊ Hemophilia	◊ Respiratory Disease	◊ Anxiety Disorder

Please list any diseases, conditions or problems not checked above _____
_____
Please list all medications you are currently taking _____
_____

ABOVE INFORMATION IS TRUE:
I have read and understand the above, I acknowledge that my questions if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist(s) or any other member of the staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature_____Date_____