

## Health & Dental History

Name: \_\_\_\_\_

Have you been under the care of a medical doctor during the past two years? Y N

If so, for what? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Are you taking any medications now, including regular dosages of aspirin? Y N

If so, please list name and dosage \_\_\_\_\_

Are you aware of any allergic reaction to any medication, substance, product? Y N

If so please list \_\_\_\_\_

Indicate which of the following you have had or have at the present by circling "Y":

Heart Disease	Y	Congested Ears	Y
Heart Murmur	Y	Dizziness	Y
High Blood Pressure	Y	Ringling Ears	Y
Mitral Valve Prolapse Congenital	Y	Loose Teeth	Y
Artificial Heart Valve	Y	Posture Problems	Y
Pacemaker	Y	Clenching	Y
Stroke	Y	Grinding	Y
Asthma	Y	Facial Pain	Y
Liver Disease/Jaundice	Y	Sensitive Teeth	Y
Latex Sensitivity	Y	Neck Pain	Y
Artificial Joints	Y	Bell's Palsy	Y
Kidney Trouble	Y	Difficulty Swallowing	Y
Radiation/Chemotherapy	Y	Difficulty Chewing	Y
Epilepsy/Seizures/Fainting	Y	Trigeminal Neuralgia	Y
Diabetes	Y	Tingling in Arms/Fingers	Y
Hepatitis	Y	Insomnia/Frequent Waking	Y
AIDS/HIV	Y	Have you had braces?	Y
Sickle Cell Disease	Y	Do you see a chiropractor?	Y
Neurological Disorders	Y	Does floss shred when using?	Y
Headaches	Y	Food catches between teeth?	Y
Jaw Pain	Y	Do you use any form of tobacco?	Y
Jaw Popping	Y	Do your gums bleed?	Y
Limited Opening	Y	Does your breath concern you?	Y
Hemophilia/Blood Disorder	Y	Tuberculosis	Y
Arthritis	Y	Do you snore?	Y
Rheumatic Fever	Y	Do you wake up with sore jaws?	Y

Do you have or have you had any disease, condition or problem not listed? Y

If yes, please describe \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ Relation: \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone # 2 \_\_\_\_\_

Women- Are you: Pregnant: Y Nursing: Y Taking Birth control pills: Y

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email Address \_\_\_\_\_

Home Address: \_\_\_\_\_, City, Zip: \_\_\_\_\_

For more information, please visit our web site at [www.eid-dentistry.com](http://www.eid-dentistry.com).

We appreciate your interest in our dental practice. We'd like to help you find out if our dental practice is right for you.

You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive. All of our treatment is designed to be comfortable, to be long-lasting, and to exceed your expectations. We use the latest technology and techniques our profession has to offer.

Our biggest strength lies in how you are treated. We allow extra time so that you are never rushed. We want to know what we can do to develop the best possible professional relationship with you.

We provide state of the art cosmetic dentistry, but *what does that mean?*

A large part of our practice involves the type of procedures you may have seen on television, such as whitening and porcelain veneers for your front teeth. However cosmetic dentistry is also for your back teeth. This aspect of our practice involves replacing worn-out and unattractive dental work with beautiful, natural-looking porcelain restorations. If you have dark mercury-silver fillings, mismatched caps that appear dark at the gum-line, or chipped/broken teeth, we can help you.

Another important part of our practice is **functional dentistry**. This involves helping people with TMJ/TMD. If you have worn-down teeth, headaches, clicking in the jaw joint, face/neck pain or bite problems, we can help you with that as well.

By filling out the enclosed questionnaires, we find out what areas of dentistry you are interested in. You may find that by combining our areas of expertise, you can achieve the best results. During the examination phase, we are here to show you what we see. Ultimately, whatever treatment you receive is your choice, our training allows us to provide you with the possibilities. We offer a variety of payment options to help meet your individual needs. Please take a moment to complete the enclosed forms and *return them to us two days prior to your appointment.*

This will greatly enhance your visit.

Because you are an active participant in your treatment, knowing what is important to you about your smile, both cosmetically and functionally, is helpful to us. We look forward to seeing you!

Sincerely,  
Dr. Firouzian and Team

Our office is unique and unlike any dental office you have ever been to. Your upcoming visit is an important first step toward getting the dentistry you seek, We place a high emphasis on helping you determine your present as well as your future dental needs, wants, and desires. Here are some things we are going to be discussing at your first visit. These are some issues you may have considered before. Please answer these questions in a way that best expresses how you feel. Your answers will help us to prepare for your visit so that we may better serve you.

1. Are you having any areas of concern? \_\_\_\_\_  
\_\_\_\_\_
2. What do you think is the current state of your mouth's health? \_\_\_\_\_
3. How healthy do you want us to get your mouth? (check one):  
 Pain relief/repairs only  Average  The best it can be
4. Tell us about your good dental experiences \_\_\_\_\_  
And the bad ones \_\_\_\_\_
5. Why did you leave your last dental office? \_\_\_\_\_
6. Is there something about your smile you would you like to improve?  
\_\_\_\_\_
7. What would it take for you to trust us to be your dentist? \_\_\_\_\_
8. Do you have any friends or family that already come to our office? Y\_\_\_ N\_\_\_
9. What do you already know about our office and what are your expectations?  
\_\_\_\_\_
10. Has fear ever been an issue for you in a dental office? Y\_\_\_ N\_\_\_
11. Has time ever been an issue for you in getting your dental work done? Y\_\_\_ N\_\_\_
12. Has the cost of dental treatment been a concern for you? Y\_\_\_ N\_\_\_
13. We have the unique ability to look at your mouth from three different perspectives. Which of these would you like us to use for you? (Please check all that apply):  As a general dentist  As a cosmetic dentist  As a functional dentist
14. At what point do you want us to initiate treatment? (please check one):  
 When my tooth hurt/breaks  When something is worsening  When not ideal
15. What quality of dentistry do you want us to recommend?  
 Repairs,  Average  Ideal/The best
16. What additional information would you like us to know? \_\_\_\_\_  
\_\_\_\_\_
17. How did you hear about our office? (Please check all that apply):  
 Personal referral from \_\_\_\_\_  
 TV  Internet  L.V.I. advertisement  Postcard  Newspaper  
 Magazine  Local publication
18. If you found us on the Internet, what search words did you use? \_\_\_\_\_

## Comfort Menu

Your comfort is our priority. We provide a variety of services to assure you are comfortable at all times. Please select from the following menu of you prefer any of these options.

Patients find that if they take an analgesic prior to treatment, it helps later in the day.

Which do you prefer?  Tylenol  Advil  Other

We provide various levels of sedation to ease your mind. Would you benefit from a sedative?  Y  N

**If yes**, please circle: Nitrous Oxide, Mild Sedative, Moderate Sedative

*The wand is today's most comfortable numbing technology and we use it routinely. Used in combination with a topical medication from the dermatology profession, The Wand allows you to get numb feeling virtually nothing.*

Our rooms are equipped with DVD and VHS players and "virtual reality" movie glasses. Watching movies and videos is an excellent way to pass time during your visit. Would you like to watch a movie?  Y  N

What type of movies do you like? \_\_\_\_\_

We have movies on site or please feel free to bring your own.

What type of music do you like, our patient IPod has music specifically prepared for our patient's enjoyment during longer appointments.

Blankets help keep you warm and relaxed through your visit. Would you like a blanket?  Y  N

Pillows provide an extra measure of comfort whether you have a sore back or you would just like something to hold on to. Would you like pillows?  Y  N

A courtesy telephone is always available to you. Please let us know if you need to make a call and we will provide you with a portable telephone.

Is there anything else we can do for you to make your visits as comfortable as possible?

\_\_\_\_\_  
\_\_\_\_\_