Sam Sajoo, D.D.S., M.S.
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Thank you for selecting our dental health care team!
We will strive to provide you with the best possible dental care.
To help us meet all your dental health care needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date: _____

Name: _____ Wishes to be called: _____

S.S. #: _____ Date of Birth: _____

Drivers License: _____ _____

❑ Male ❑ Female ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Address: _____ Home Phone: _____

City: _____ State _____ Zip _____ Work Phone: _____

Employer: _____ Occupation _____ Cell Phone: _____

Referred by: _____ Employment Status: ❑ Full Time ❑ Part Time ❑ Retired

E-mail: _____ ❑ I would like to receive correspondences via E-mail

On a scale of 1-10 (10 being the highest), what priority do you give your teeth? 1 2 3 4 5 6 7 8 9 10

(we ask this question to avoid similar error)

Reason for leaving former dentist: _____

Purpose of visit today: _____

Date of last dental exam: _____ Date of mouth x-ray: _____

Responsible Party (if other than patient)

Name: _____ S.S. #: _____

Relation to patient: _____ Home Phone: _____

Address: _____ Work/Cell Phone: _____

City _____ State _____ Zip _____

Primary Insurance Information

Name of insured: _____

Insured S.S. #: _____ Date of Birth: _____

Employer: _____ Group # _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip _____

Relation to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary Insurance Information

Name of insured: _____

Insured S.S. #: _____ Date of Birth: _____

Employer: _____ Group # _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip _____

Relation to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other

Authorization and Release

I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my child, during the period of such dental care to third party payors and/or health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the fee for services and that the policy is an arrangement between the insurance company and myself. I understand all services rendered me will be immediately due and payable.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. In the case of default on payment of this account, I agree to pay all costs, including interest at 18% per annum, collection cost and reasonable attorney fees incurred in attempting to collect on this amount or any future account balances.

X _____

Signature of patient or parent, if minor — Date

Thank you for filling out this form completely. The information you have provided will help us serve your dental health care needs more effectively and efficiently. If you have any questions at any time, please ask - we are always happy to help.

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MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken orally or been given IV any medications containing Bisphosphonates such as Fosomax, Boniva, Actonel or Reclast? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No _____
Do you use controlled substances? ◯ Yes ◯ No _____

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthesia
❑ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____