GORDON L. PATTISON, DDS, APDC
RANA G. SHAHI, DDS, MS, MSD
11859 WILSHIRE BLVD., SUITE 550, LOS ANGELES, CALIFORNIA 90025 **Date**: _____

Patient Information

Patient Name: _____ Preferred Name: _____
Title Last First MI

Address: _____
Street Apartment #

_____
City State Zip Code

Sex: M F Birthdate: _____ Circle one: Married Divorced Single Minor

Phone: Home: _____ Work: _____ Ext: _____ Cell: _____

E-mail: _____ Social Security Number: _____

Occupation: _____

Medical History

Have you ever had any of the following? Please circle Yes or No.

AIDS/HIV Infection	Yes No	Excessive Bleeding	Yes No	Low Blood Pressure	Yes No	Stroke	Yes No
Allergies	Yes No	Fainting	Yes No	Mental Disorders	Yes No	Thyroid Condition	Yes No
		Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Anemia	Yes No	Head Injuries	Yes No	Nervous Disorders	Yes No	Tuberculosis	Yes No
Arthritis	Yes No	Heart Disease	Yes No	Pacemaker	Yes No	Tumors	Yes No
Artificial Joints	Yes No	Heart Murmur	Yes No	Pregnancy	Yes No	Ulcers	Yes No
Asthma	Yes No	Heart Problems	Yes No	Due date:	_____	Venereal Disease	Yes No
Blood Transfusion	Yes No	Hepatitis	Yes No	Psychiatric Care	Yes No	Codeine Allergy	Yes No
Cancer	Yes No	Herpes (Genital)	Yes No	Radiation Treatment	Yes No	Latex Allergy	Yes No
Chemotherapy	Yes No	Herpes (Oral)	Yes No	Respiratory Problems	Yes No	Penicillin Allergy	Yes No
Circulatory Problems	Yes No	High Blood Pressure	Yes No	Rheumatic Fever	Yes No	OTHER:	
Diabetes	Yes No	Jaundice	Yes No	Rheumatism	Yes No	_____	
Dizziness	Yes No	Kidney Disease	Yes No	Sinus Problems	Yes No	_____	
Epilepsy	Yes No	Liver Disease	Yes No	Stomach Problems	Yes No	_____	

- Have you ever had any complications following dental treatment? Yes No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
  If yes, please explain: _____
- Are you now under the care of a physician? Yes No
  If yes, for what conditions? _____
- Name of Physician: _____ Phone: _____
- Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? Yes No
  If yes, please explain: _____
- Are you taking any medication at this time? Yes No
  Please list medications: _____
- Do you tolerate aspirin or anti-inflammatory drugs (Motrin, Advil, Aleve)? Yes No
- Do you have a prosthetic device implanted (i.e. hip, heart valve replacement, pacemaker, etc.)? Yes No
- Do you smoke or use tobacco? Yes No
- Do you take aspirin regularly? Yes No
- **Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)?** Yes No
- **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO LATEX OR RUBBER PRODUCTS?** Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

Date: _____ _____ _____
Signature of patient, parent or guardian Reviewed By

Dental Insurance Information

Primary Insurance

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Address: _____

_____

City State Zip

Subscriber's DOB: _____ Subscriber ID#: _____ Group #: _____

Employer Name: _____

Insurance Co. Name: (i.e. Delta Dental, Aetna, MetLife) _____

Ins. Co. Address: Ins. Co. Phone:

Secondary Insurance

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Address: _____

_____

City State Zip

Subscriber's DOB: _____ Subscriber ID#: _____ Group #: _____

Employer Name: _____

Insurance Co. Name: (i.e. Delta Dental, Aetna, MetLife) _____

Ins. Co. Address: _____ Ins. Co. Phone: _____

Emergency Contact and Referral Information

Whom may we thank for referring you to our practice? ☐ Friend ☐ Relative ☐ Dentist ☐ Other

Name of person or office referring you to our practice: _____

Emergency Contact: Name_____ Phone _____ Relationship_____

Financial Consent

All accounts are due and payable at time of service rendered, unless prior arrangements have been made. If it is desired to extend payments for more than 30 days, specific arrangements must be made with our office. These extended payment courtesies are made at no interest or finance charge provided payments are received as promised.

To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare the necessary forms or reports to help you obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay our fees.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

Consent for Periodontal Services

I hereby authorize and request the above named doctor and his auxiliaries to perform for me all periodontal therapy and surgery indicated in my dental records and to do whatever procedures are deemed advisable in his judgment. I will discuss any aspect of my treatment I do not understand with my periodontist. I acknowledge that the benefits and risks of periodontal therapy are understood prior to accepting treatment.

I also authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the above named doctor.

It has been explained to me, and I understand, that results are not, and cannot be, guaranteed or warranted.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian