NEW PATIENT FORM

Beverly Hills Periodontics & Dental Implant Center
Peiman Soleymani DDS
Diplomate of American Board of Periodontology

We are pleased to welcome you to our practice. Please download this form, fill out completely and email as an attachment to peiman.soleymani@outlook.com.

If you have any questions we'll be glad to help you. We look forward to working with you to maintain your dental health.

PATIENT INFORMATION

Name: _____ SS#: _____
Last First Initial

Address: _____
Street City Zip

Home No: _____ Cell. No: _____ Office No: _____

Birth date: _____ Male/Female: _____ Email Address: _____

Marital Status: _____ Age: _____ Drivers License/CAL ID: _____

Employer: _____ Occupation/ Position: _____

Office Address: _____

Person to contact in Case of an Emergency: _____ Phone No: _____

Whom May We Thank for Referring You? _____

PRIMARY INSURANCE

Name of Insurance Plan: _____ Group No: _____

Person Responsible for Account: _____ SS#: _____

Relation to Patient: _____ Birth date: _____

Insured's Employer: _____ Bus. Phone No: _____

Do you have Secondary Insurance? _____ Name of Insurance Plan: _____

Name of Former Dentist: _____ Phone No: _____

Date of Last Dental Care: _____ Date of Last X-Rays: _____

How often do you brush? _____ Floss: _____

How may we serve you today? _____

How do you feel about the appearance of your teeth?: _____

KINDLY CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

Bad Breath	☐	Food Collection Between Teeth	☐	Periodontal Treatment	☐
Bleeding Gums	☐	Grinding/Clenching Teeth	☐	Sensitivity To Hot/Cold	☐
Clicking/Popping Jaw	☐	Loose Teeth or Broken Fillings	☐	Sores/Growths in Mouth	☐
Amalgam Fillings	☐	Migraines/Headaches	☐	Snoring/Sleep Apnea	☐
Sports Activities	☐	Sports Guard	☐	Teeth Whitening	☐

NEW PATIENT FORM

MEDICAL HISTORY

Are you currently under a physician's care? _____ for what condition: _____

Dr.'s Name: _____ Dr.'s Phone No._____

Have you had any serious illness or operation? _____ if yes, please describe: _____

Have you ever had a blood transfusion? _____ If yes, approximately when? _____

For women: Are you pregnant? _____ Nursing? _____ Taking Birth Control Pills? _____

PLEASE CIRCLE YES OR NO IF YOU HAVE HAD ANY OF THE FOLLOWING:

Rheumatic Fever	O Y O N	Heart Problem	O Y O N	Heart Murmur	O Y O N
Pacemaker/Heart Surgery	O Y O N	Artificial Heart Valves	O Y O N	Shortness of Breath	O Y O N
Surgical Implants	O Y O N	Low Blood Pressure	O Y O N	High Blood Pressure	O Y O N
Stroke	O Y O N	Fainting/Dizziness	O Y O N	Headaches	O Y O N
Epilepsy	O Y O N	Kidney Disease	O Y O N	Swelling of the Feet/Ankle	O Y O N
Persistent Cough	O Y O N	Tuberculosis	O Y O N	Sinus Problem	O Y ⊙ N
Cough Up Blood	O Y O N	Respiratory Disease	O Y O N	Tobacco Habit	O Y O N
Blood Disease	O Y O N	Liver Disease	O Y O N	Hepatitis	O Y O N
Anemia	O Y O N	Cancer	O Y O N	Radiation Therapy	O Y O N
Chemotherapy	O Y O N	Diabetes	O Y O N	Parathyroid Disease	O Y O N
Thyroid Disease	O Y O N	Stomach Ulcers/Colitis	O Y O N	Skin Rash	O Y O N
Food Allergies	O Y O N	Anaphylaxis	O Y O N	Metallic Allergies	O Y O N
Back Problems	O Y O N	Nervous Problems	O Y O N	Psychiatric Care	O Y O N
AIDS/HIV Positive	O Y O N	Herpes/Genital Herpes	O Y O N	Venereal Disease	O Y O N
Cortisone Treatment	O Y O N	Rapid Weight Gain/Loss	O Y O N	Glaucoma	O Y O N
Arthritis	O Y O N	PHEN-FEN	O Y O N	Latex Sensitivity	O Y O N

List Any Medications You Are Currently Taking:

_____

_____

Allergies, If Any:

_____

_____

AUTHORIZATION

I have reviewed the information on this questioner, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment whether or not paid by insurance. I understand that I am responsible for all charges incurred whether or not paid by insurance.

_____ _____
Signature Date

_____ _____
Doctor's Signature Date

I have been given the copy of notice of HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT of 1996 (HIPAA).

_____ _____
Signature Date