SMILE gallery Austin

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 you. Welcome to Smile Gallery of Austin!

DR. AHMAD AHMADIAN DDS

Patient Information (CONFIDENTIAL)

Name _____ Gender _____ Birth Date _____

Phone _____ Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Social Security _____ Driver's Licence/ID _____

Check Appropriate Choice: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's/Parent's Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Person to Call in Case of Emergency _____ Phone _____ Relationship _____

How did you hear about our office? _____

Insurance Information

Name of Insured Party _____ Relationship to Patient _____

Birth Date _____ Social Security _____ Insurance Company _____

Member ID _____ Group Number _____

Patient Medical History

Are you pregnant? ☐Yes ☐No Are you nursing? ☐Yes ☐No Are you taking birth control pills? ☐Yes ☐No

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

Yes	No	Anemia / Radiation Treatment	Yes	No	Hemophilia / Abnormal Bleeding
Yes	No	Arthritis	Yes	No	Hepatitis
Yes	No	Artificial Joints / Bones / Valves	Yes	No	High / Low Blood Pressure
Yes	No	Asthma	Yes	No	HIV+ / AIDS
Yes	No	Blood Transfusion	Yes	No	Hospitalized in the past 2 years
Yes	No	Cancer Chemotherapy	Yes	No	Kidney Problems
Yes	No	Congenital Heart Defect	Yes	No	Mitral Valve Prolapse
Yes	No	Diabetes	Yes	No	Psychiatric Problems
Yes	No	Difficult Breathing	Yes	No	Rheumatic / Scarlet Fever
Yes	No	Drug / Alcohol Abuse	Yes	No	Severe / Frequent Headaches
Yes	No	Emphysema / Glaucoma	Yes	No	Shingles
Yes	No	Epilepsy / Seizures / Fainting	Yes	No	Sickle Cell Disease / Traits
Yes	No	Fever Blisters / Herpes	Yes	No	Sinus Problems
Yes	No	Heart Attack / Stroke	Yes	No	Thyroid Problems
Yes	No	Heart Murmur	Yes	No	Tuberculosis
Yes	No	Heart Surgery / Pacemaker	Yes	No	Venereal Disease

Please list any other serious medical conditions/surgeries that you have ever had: _____

PT. NAME _____

Medications

Please list any medications you are currently taking: _____

_____

_____

Patient Dental History

Do your gums bleed while brushing or flossing?	Yes	No
Are your teeth sensitive to hot or cold liquids/foods?	Yes	No
Are your teeth sensitive to sweet or sour liquids/foods?	Yes	No
Do you feel pain to any of your teeth?	Yes	No
Do you have any sores or lumps in or near your mouth?	Yes	No
Have you had any head, neck, or jaw injuries?	Yes	No

Have you experience any of the following problems in your jaw?

Clicking	Yes	No
Pain (joint, ear, side of face)	Yes	No
Difficulty opening or closing	Yes	No

Do you have frequent headaches?	Yes	No
Do you clench or grind your teeth?	Yes	No
Do you bite your lips or cheeks frequently?	Yes	No
Have you ever had any difficult extractions?	Yes	No
Have you had any orthodontic work?	Yes	No
Have you ever had any prolonged bleeding following extractions?	Yes	No
Have you ever had instruction on the correct method of brushing your teeth?	Yes	No
Have you ever had instruction on the care of your gums?	Yes	No

Comments: _____

Cosmetic

Are you interested in having an aesthetic smile evaluation done by the Doctor to keep improving your smile and confidence?	Yes	No
Do you have any missing teeth that you would like to have replaced with a dental implant?	Yes	No
Do you have other aesthetic concerns with your smile that you would like to discuss?	Yes	No

Please list: _____

_____

Allergies

Are you allergic to any of the following:

Yes	No	Aspirin
Yes	No	Codeine
Yes	No	Dental Anesthetics
Yes	No	Erythromycin
Yes	No	Jewelry / Metals
Yes	No	Latex
Yes	No	Penicillin
Yes	No	Tetracycline

Please list any other drugs/materials you are allergic to: _____

_____

_____

_____

Authorization & Release

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the 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 insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf, or on that of my dependants.

X _____

Signature of Patient or Parent

X _____

Signature of Doctor