ADDITIONAL CONTACT NUMBERS

PAGERS: ____________

CELLULAR: ____________

E-MAIL ____________

Date ____________

WALI HAMIDY, D.M.D.
4150 REGENTS PARK ROW
SUITE 200
LA JOLLA, CA 92037

ACCT.# ____________

Victor # ____________

INS.# ____________

Home Phone ____________

PATIENT INFORMATION

Patient Name ____________ (Last Name) ____________ (First Name) SS# ____________

Address ____________ Drivers Lic. # ____________

City ____________ State ____________ Zip ____________ Home Phone ____________

Sex ☐ M ☐ F Birthdate ____________ Age ____________ Marital Status ____________

Patient Employed By ____________ Occupation ____________

Are you a full/part time student? ☐ Yes ☐ No Where? ____________

Business Address ____________ Work Phone ____________

Have any of your family members been into our office? ____________

How were you referred? ☐ Patient referral Who may we thank? ____________

☐ Telephone Book ☐ Saw Bldg./Sign Employer ☐ Penny Saver ☐ Advertisement (Which?) ____________

☐ 1-800 Dentist ☐ Dental referral service ☐ Dr. Referral

In case of Emergency, who should be notified? ____________

Relationship ____________ Address ____________ Phone ____________

PRIMARY INSURANCE

Person Responsible for Account ____________ (Last Name) ____________ (First Name) ____________ (Initial)

Relationship to Patient ____________ Reponsible Person Birthdate ____________

Address (if different from patient's) ____________ Phone ____________

City ____________ State ____________ Zip ____________

Person Responsible Employed by ____________

Business Address ____________ Bus. Phone ____________

Insurance Company ____________

Group # ____________ SS # ____________ Contract # ____________

Names of other dependents covered under this plan ____________

SECONDARY INSURANCE

Is patient covered by additional insurance ____________ ☐ Yes ☐ No

Subscriber Name ____________ Relationship to Patient ____________ Birthdate ____________

Address (if different from patient's) ____________ SS # ____________

City ____________ State ____________ Zip ____________ Phone ____________

Subscriber Employed by ____________ Bus. Phone ____________

Group # ____________ Subscriber# ____________ Contract# ____________

Names of other dependents covered under this plan ____________

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Barcode #: 5271086

Account #: 40297

DENTAL HISTORY

Reason for Today's Visit ______________________________

Former Dentist ______________________________ Phone ______________

Date of last dental care ______________________ Date of last dental x-rays ______________

Check (✓) if you have had problems with any of the following:

- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Loose teeth or broken fillings
- ☐ Grinding teeth
- ☐ Periodontal Treatment
- ☐ Sores or growth in mouth
- ☐ Sensitivity to hot or cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting

Do you wear dentures or partial dentures?__________ If so, when were they made?______________

Is there any other information we should know about any other dental visits? ______________

____

MEDICAL HISTORY

Physician's Name ______________________________ Date of Last Visit ______________

Have you had any serious illness or operations?______________ If yes, describe ______________

____

Have you ever had a blood transfusion?__________ if yes, give dates ______________

(women) Are you pregnant? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✓) if you have or have had any of the following:

- ○ Aids
- ○ Anemia
- ○ Arthritis, Rheumatism
- ○ Artificial Joints
- ○ Asthma
- ○ Back Problems
- ○ Blood Disease
- ○ Cancer
- ○ Chemical Dependency
- ○ Chemotherapy
- ○ Circulatory Problems
- ○ Cortisone Treatments
- ○ Cough (persistent)
- ○ Cough up blood
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Headaches
- ○ Heart Murmur
- ○ Heart Problems
- ○ Hemophilia
- ○ Hepatitis A or B
- ○ High Blood Pressure
- ○ HIV Positive
- ○ Jaw Pain
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mitral Valve Prolapse
- ○ Nervous Problems
- ○ Pacemaker
- ○ Psychiatric Care
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Rheumatic Fever
- ○ Scarlet Fever
- ○ Shortness of Breath
- ○ Skin Rash
- ○ Stroke
- ○ Swelling of Feet or Ankles
- ○ Thyroid Problems
- ○ Tobacco Habit
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Ulcer
- ○ Venereal Disease

MEDICATIONS

List Medications you are currently taking

____

Pharmacy Name ______________________________ Phone # ______________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________

Doctor's Notes ______________________________

____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ______________________________

Signature ______________________________

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