Dentistry for the busy professional

120 Battery Street - San Francisco, CA 94111 - (415)391-4466
info@CitiDentOnline.com

PATIENT INFORMATION

Patient Name ______________________

Date __________ **Birthday** __________

SS# or Insurance ID# __________ **Gender** ☐ M ☐ F

Address ______________________

City ________ **State** ______ **Apt #** ______ **Zip** ______

Home Tel __________ **Work Tel** __________

Mobile # __________ **Occupation** __________

Email __________ ☐ Married ☐ Single

HOW DID YOU HEAR ABOUT US?

☐ Google ☐ Friends/Family/ Co-Worker ☐ Yelp

☐ DemandForce ☐ Insurance Website ☐ Another Dentist

☐ UCSF ☐ CitiDent Gift Card ☐ ZocDoc

Name of the person/dentist/other referred by: ☐ Other

____

EMPLOYER

Employer ______________________

Address ______________________

City __________ **State** ______ **Zip** ______

Phone __________ **Position Held** __________

Notes ______________________

____

EMERGENCY CONTACT

Emergency Contact Name ______________________

Address ______________________

City __________ **State** ______ **Zip** ______

Phone __________ **Relationship** __________

INSURANCE INFORMATION

Responsible Party Name ______________________

Relationship to Patient ☐ Self ☐ Parent ☐ Spouse/Partner

Primary Insurance Company ______________________

Secondary Insurance Company ______________________

Subscriber Name ______________________

Group # __________ **SS #** __________

Birthday __________ **Other Coverage** ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

____

and have assigned all my benefit payments directly to CitiDent, Ben G. Amini, DDS. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. CitiDent, Ben G. Amini, DDS may use my health care information and may disclose such information in the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. We are NOT In-Network with ALL dental benefit providers. If it is important for you to see an in-network provider, please contact your benefit provider to find out if they consider CitiDent dentists and specialists as In-Network, BEFORE your first visit and prior to receiving dental treatment.

Signature __________ **Date** __________

MEDICATION & ALLERGIES

Please list all the medication you are currently taking: ______________________

____

____

____

____

____

____

____

Are you allergic to any of the following?

Aspirin/Ibuprofen: ☐ Yes ☐ No Codeine: ☐ Yes ☐ No

Sulfa Drugs: ☐ Yes ☐ No Latex, Metals: ☐ Yes ☐ No

Penicillin/Amoxicillin ☐ Yes ☐ No Local Anesthesia: ☐ Yes ☐ No

Please list any other known allergies ______________________

____

____

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Thank you in advance for taking the time to complete the following forms. The responses to these questions will allow us to customize the care to your individual needs, to better understand your existing condition, and to help us improve your dental health in a personalized manner. At CitiDent, we believe in individualized care, educational patient experience, and a unique approach to dental care -- an approach that may change the way you feel about going to the dentist. We truly thank you for choosing us, and we look forward to seeing you on your first visit.

DENTAL HISTORY

Reason for your visit ______________________________

Date of your last dental Exam ______________________ **Date of your last dental X-Rays** ______________________

Date of your last teeth cleaning ______________________ **Name of your last dentist** ______________________

Have you ever had any serious complications associated with a previous dental treatment? ☐ Yes ☐ No **If Yes, please explain** ______________________

____

How do you rate the overall health of your teeth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the health of your teeth and gums rank high in your priorities? ☐ Yes, A Healthy Mouth, A Healthy Life ☐ Somewhat Important ☐ I'll Wait Till it Hurts!

Do you clench or grind your teeth? ☐ Yes ☐ No ☐ Not Sure **Does your jaw pop or click?** ☐ Yes ☐ No

Do you gag easily? ☐ Yes ☐ No **Does food or floss get stuck in between some of your teeth?** ☐ Yes ☐ No

Are your teeth sensitive to hot or cold? ☐ Yes ☐ No **Do you have a dry mouth?** ☐ Yes ☐ No

Are you happy with the appearance of your smile? ☐ Yes ☐ No ☐ It Can Be Improved **If No, please explain** ______________________

____

Does your breath concern or bother you? ☐ Yes ☐ No ☐ It Can Be Improved

During my exam, I would like to know more about: (please check all that apply):

☐ Whiter teeth ☐ Healthier gums ☐ A Better smile ☐ Replacing missing teeth ☐ Eliminating pain/discomfort

☐ Fresher breath ☐ A Better bite ☐ Healthier teeth ☐ Straightening my teeth ☐ Fixing broken or fractured teeth

☐ Preventing cavities ☐ My wisdom teeth condition ☐ Botox®- cosmetic ☐ Other ______________________

Doctor's Notes ______________________________

Home Care/ Hygiene

How often do you brush? ☐ Once Evening ☐ Once Morning ☐ Both Morning and Evening ☐ Not Daily

How often do you floss? ☐ Once Evening ☐ Once Morning ☐ Both Morning and Evening ☐ Not Daily ☐ I Don't Floss

What texture toothbrush do you use? ☐ Soft ☐ Medium ☐ Hard ☐ Nylon ☐ Not Sure

What type of toothbrush do you use? ☐ Electric Brush ☐ Manual Brush

Doctor's Notes ______________________________

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Gums

Do your gums bleed when? ☐ Brushing ☐ Flossing ☐ Both ☐ No

Do your gums feel tender or swollen? ☐ Yes ☐ No

Have you had deep cleaning before? ☐ Yes ☐ No

Have you had gum surgery before? ☐ Yes ☐ No If yes, when? ____________

Have you ever been treated for periodontal disease, gum recession or pocket reduction? ☐ Yes ☐ No **If yes, when?** ________

Do you have or have gotten any bumps, ulcers, or canker sores, on your gums, cheek, tongue or palate? ☐ Yes ☐ No

Doctor's Notes ____

Teeth

Do you have any fillings? ☐ Yes ☐ No ☐ I Don't Know

Are your fillings over 5 yrs old? ☐ Yes ☐ No ☐ N/A

Do you have Silver/Mercury metal fillings? ☐ Yes ☐ No

If old fillings need replacement, what material do you prefer: ☐ Silver/Mercury/Metal ☐ Tooth Colored Resin/Porcelain ☐ Gold

Do you have Crowns/Onlays? ☐ Yes ☐ No ☐ I Don't Know

If yes, are your Crowns/Onlays over 10 yrs. old? ☐ Yes ☐ No ☐ N/A

If Yes, are you happy with the fit and appearance of your crowns? ☐ Yes ☐ No **If no, please explain** ____________________

If old Crowns/Onlays need replacement, what material do you prefer: ☐ Tooth Colored Porcelain ☐ Metallic/Gold

Doctor's Notes ____

SMILE

Part of the comprehensive dental examination is the appearance of your smile.
Would you like us to evaluate your smile? Do you have questions as to how your smile can be improved?

☐ Yes, I would like to know the options to improve my smile ☐ No, we can skip this part of the exam

BEHAVIORAL HISTORY

How would you rate your Personality? ☐ Type A ☐ A Happy Camper ☐ In Between

What is your current stress level? ☐ Low ☐ Moderate ☐ High

Have you been more stressed in the past three months? ☐ Yes ☐ No

Do you snore or have been told you do? ☐ Yes ☐ No

Do you have a hard time sleeping? ☐ Yes ☐ No

Do you have or have been diagnosed with sleep apnea? ☐ Yes ☐ No

Does going to the dentist make you anxious? ☐ Yes ☐ No

Which of the following do you consume daily? ☐ Snacks ☐ Energy Drink ☐ Soda ☐ Coffee ☐ Tea ☐ Candy

In the past, what did you dislike "the most" about going to the dentist?

☐ Shots ☐ Sound of The Instruments ☐ Smell of Dental Office ☐ Fear of Having Cavities ☐ Dentist's Bedside Manner ☐ Other ________

Doctor's Notes ____

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HEALTH HISTORY

Physician Name ______________________ **Physician Tel.** ______________________ **Date of last physical Exam** ______________________

Do you have a family history of high blood pressure, diabetes, stroke, or cancer? ☐ Yes ☐ No

Please list ____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen? ☐ Yes ☐ No

These include combinations of Ionamin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Have you ever had Botox®- Cosmetic or Juvederm®? ☐ Yes ☐ No

Have you taken, or are currently taking, bone mass medications such as (Bisphosphonates, Fosamax, Zoledronic Acid-Zometa Pamidronate-Aredia)? ☐ Yes ☐ No

Place a mark on "Yes" or "No" to indicate if you have or have had any of the following:

AIDS/HIV ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Arthritis, Rheumatism ☐ Yes ☐ No
Antibiotics Before Dental Treatment ☐ Yes ☐ No
Artificial Heart Valves ☐ Yes ☐ No
Artificial Joints ☐ Yes ☐ No
Asthma ☐ Yes ☐ No
Back Problems ☐ Yes ☐ No
Bleeding Problems ☐ Yes ☐ No
Blood Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Chemical Dependency ☐ Yes ☐ No
Chemotherapy ☐ Yes ☐ No
Circulatory Problems ☐ Yes ☐ No
Congenital Heart Lesions ☐ Yes ☐ No
Cortisone Treatments ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Emphysema ☐ Yes ☐ No
Epilepsy ☐ Yes ☐ No

Fainting or Dizziness ☐ Yes ☐ No
Glaucoma ☐ Yes ☐ No
Headaches ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Heart Problems ☐ Yes ☐ No
Hepatitis Type __ ☐ Yes ☐ No
Herpes ☐ Yes ☐ No
High Blood Pressure ☐ Yes ☐ No
Jaundice ☐ Yes ☐ No
Jaw Pain ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Liver Disease ☐ Yes ☐ No
Low Blood Pressure ☐ Yes ☐ No
Mitral Valve Prolapse ☐ Yes ☐ No
Nervous Problems ☐ Yes ☐ No
Osteoporosis ☐ Yes ☐ No
Pacemaker ☐ Yes ☐ No
Psychiatric Care ☐ Yes ☐ No
Radiation Treatment ☐ Yes ☐ No

Recreational Drug Use *Now or in The Past* ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Shortness of Breath ☐ Yes ☐ No
Sinus Trouble ☐ Yes ☐ No
Skin Rash ☐ Yes ☐ No
Special Diet ☐ Yes ☐ No
Steroids Treatment ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Swollen Feet or Ankles ☐ Yes ☐ No
Swollen Neck Glands ☐ Yes ☐ No
Thyroid Problems ☐ Yes ☐ No
Tonsillitis ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Tumor or Growth on Head or Neck ☐ Yes ☐ No
Ulcer ☐ Yes ☐ No
Venereal Disease ☐ Yes ☐ No
Depression, Emotional, Physiological Disorder or Episodes ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No **If yes, how many cigarettes per day?** ______________ **Do you take any supplements?** ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No **If yes, how many per week?** ______________

Women: Are you pregnant? ☐ Yes ☐ No **If yes, due date:** __________ **Are you nursing?** ☐ Yes ☐ No **Birth Control Pills?** ☐ Yes ☐ No

Doctor's Notes: ____

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Thank you for taking the time to fill out these important questions. We are delighted to have you as a patient in our office. We will do everything in our ability to offer you personalized care and an exceptional experience during your visit. Thank you again and Welcome to CitiDent.

What to expect during your first visit:

At CitiDent, our team is committed to provide you with positive, educational and efficient dental care. Your first visit will include a full mouth dental examination, during which we will need to have a full mouth digital radiographs (dental x-rays). If you have a RECENT full mouth high quality film or digital radiographs (x-rays) from your previous dentist, please bring the ORIGINAL FILM or email the Digital PDF file to us at least 48 business hours prior to your first visit.

The New Patient Examination includes:

- A head and neck muscle evaluation
- Jaw joint evaluation
- Teeth and gums examination
- Oral cancer screening
- Occlusal (bite) evaluation
- Oral hygiene evaluation
- Full radiographic (x-ray) evaluation
- Full mouth intra-oral imaging evaluation- "The Tour" of your mouth in an interactive format.

The Tour

- According to many of our new patients, "The Tour" is perhaps one of the most unique features of our services at CitiDent. You get to discuss and share your goals, concerns, and priorities about your dental health with the dentist.
- After this interactive and educational discussion, a Treatment Plan is formed based on your dental needs, personal goals and priorities.
- For those patients who would like to use their dental benefit for their treatment, an **estimate** of the plan coverage is also included in the treatment plan.
- A **separate** visit is then scheduled for teeth cleaning and/or other treatment discussed on the treatment plan.

Signature ______________________ Date: ______________________

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