

# Welcome...

MOWRY DENTAL GROUP

## Raoul Shah D.D.S., Inc.

Family and Cosmetic Dentistry . . . Trust your smile to us.

**Thank you for selecting our dental healthcare team!**  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out  
his form completely in ink. If you have any questions or need  
assistance, please ask us - we will be happy to help you.

### Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
FIRST MIDDLE LAST

Email \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Drivers Lic. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box:  Female  Male Is Patient:  Married  Single  Child

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  Full Time  Part Time

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Other family members seen at our office \_\_\_\_\_

### Responsible Party / Primary Insurance Information

Name of Person Responsible for this Account \_\_\_\_\_  
FIRST MIDDLE LAST

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Drivers License # \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

### Spouse or Secondary Insurance Information

Is Patient Covered by Insurance?  Yes  No

Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
FIRST MIDDLE LAST

Drivers License # \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (If different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employed by \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

**Please Complete Both Sides**

# Dental History

Reason for Today's Visit \_\_\_\_\_

Former Dentist \_\_\_\_\_

Address \_\_\_\_\_

Date of Last Dental Care \_\_\_\_\_ Date of Last Dental X-Rays \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad Breath                    | <input type="checkbox"/> Grinding Teeth                 | <input type="checkbox"/> Sensitivity to Hot             |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets          |
| <input type="checkbox"/> Clicking or Popping Jaw       | <input type="checkbox"/> Periodontal Treatment          | <input type="checkbox"/> Sensitivity when Biting        |
| <input type="checkbox"/> Food Collection Between Teeth | <input type="checkbox"/> Sensitivity to Cold            | <input type="checkbox"/> Sores or Growths in your Mouth |
| <input type="checkbox"/> Stained Teeth                 | <input type="checkbox"/> Uneven/chipped Teeth           | <input type="checkbox"/> TMJ Problems/Pain              |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

# Medical History

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No \_\_\_\_\_

Do you require antibiotics before dental treatment?  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking Birth Control Pills?  Yes  No

Do you have or had:

- | Yes / No   | Yes / No  | Yes / No                                       | Yes / No  |
|--|---|--|---|
| <input type="checkbox"/> AIDS                          | <input type="checkbox"/> Used Biphosphonate Drugs, i.e. Fosamax | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Cortisone Treatments                   | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism         | <input type="checkbox"/> Cough, Persistent                      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/> Cough up Blood                         | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints             | <input type="checkbox"/> Diabetes                               | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Epilepsy                               | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems                 | <input type="checkbox"/> Fainting                               | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/> Glaucoma                               | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                        | <input type="checkbox"/> Headaches                              | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/> Heart Murmur                           | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Heart Problems                         | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems          | Describe _____  | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Used Phen-Fen Diet Medication |   | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Disease or Condition       |
|  |   |  | <input type="checkbox"/> Not Listed _____           |

## MEDICATIONS

List medications you are currently taking

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## ALLERGIES

- Penicillin  
 Local-Anesthetic  
 Latex  
 Any Other \_\_\_\_\_

# Authorization and Release

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay directly to the dentist or dental group Insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR PARENT IF MINOR

\_\_\_\_\_  
DATE

Our office requires a 24 hour notice to cancel an appointment. If you do not show up for your appointment or do not call us at least 24 hours ahead of your appointment to cancel, you will be charged \$25.00.