DR. AFARIN ARGHAMI, D.D.S.

12071 BRICKSOME DRIVE, BATON ROUGE, LA 70816
Phone: (225) 292-8121 Fax: (225) 293-3218

The following information is important for our records and for your health.

Name: Mr. Mrs. Miss, Dr._____ Date of Birth:_____
Mailing Address:_____ Zip Code:_____
SSN#:_____ Employer/Occupation: _____
Phone:_____ Email: _____
Emergency Contact Person: _____ Relationship:_____ Phone:_____
Person Responsible for Payment Account:_____
Who may we thank for referring you to our office? General Dentist / Other:_____
Who is your General Dentist:_____
Your Primary Physician:_____
Do you have dental insurance: NO____YES___Insurance Company/Plan name: _____

Payment is expected as services are rendered. **We are not a participant in any dental plan nor do we accept Medicare, Medicaid, or co-payments.** We will be happy to assist you with the preparation of your dental insurance forms if you have any type of coverage. We do ask, however, that you accept responsibility for the treatment fees for the services provided.

MEDICAL HISTORY

1. Have you had a thorough physical in the past year? NO_____YES_____
2. Are you currently under the care of a physician, if so, for what reason?_____
   _____
3. Please list any operations, injuries, or illnesses you have had in the past 5 years. _____
   _____
   _____
4. Have you ever had cancer? NO_____YES_____What type of cancer:_____
   If yes, what treatments were done? Chemo, radiation..? _____
5. Have you ever been diagnosed with osteoporosis/osteopenia or take any medications to treat it?
   NO_____YES_____if yes, what medications?_____
6. Have you ever been told to take antibiotic (pre-med) prior to a dental appointment? NO_____YES____
   If yes, with what antibiotic?_____ For what reason?_____
7. Please list any known drug allergies including anesthesia, general/local, latex, metals :_____
   _____

Please list ALL medications; OTC/prescription, aspirin, supplements, and vitamins you have been on in the past year:

(CONTINUED ON BACK)

8. Do you have a history of problems with any of the following:

CARDIAC	◯High blood pressure ◯ Mitral Valve Prolapse ◯ chest pains ◯ Pacemaker ◯ Heart murmur ◯ Artificial heart valve ◯ Congestive heart failure ◯ A-fib ◯ Heart attack Date of heart attack:
BLOOD	◯Anemia ◯ Clotting issues ◯ Excessive or prolonged bleeding
BRAIN	◯ Aneurysms ◯ Migraines ◯ Stroke Date of stroke:
LIVER	◯ Jaundice ◯ Hepatitis ◯ Cirrhosis ◯ Fatty liver
LUNG	◯ Active Tuberculosis/exposed to anyone ◯ Pneumonia ◯ Emphysema ◯ Shortness of breath ◯ COPD ◯ Asthma, Last attack:
KIDNEY/URINARY	◯ Kidney stones ◯ Kidney failure/dysfunction ◯ Gout ◯ Frequent infections
ENDOCRINE DISORDERS	◯ Hypo/hyperthyroidism ◯ Addison's disease ◯ **DIABETES: Type 1 / Type 2 Latest A1C**:
GASTROINTESTINAL	◯ Ulcers ◯ Diverticulitis ◯ Colitis ◯ Reflux
EPILEPSY	◯ Seizures Date of last seizure: Triggers:
AUTOIMMUNE	◯ Lupus ◯ Scleroderma ◯ Rheumatoid Arthritis ◯ Crohn's ◯ other:
INFECTIOUS DISEASE	◯HIV ◯ Hepatitis B/C ◯ Other transmissible diseases:
ARTIFICIAL JOINTS	◯ Hip ◯ Knee ◯ Shoulder ◯ Heart valve Date of latest surgery:
GLAUCOMA	◯ Left eye ◯ Right eye ◯ Closed/Open angle

TOBACCO USE: YES___NEVER___NO LONGER____ TYPE: ◯ Cigarettes ◯ Vape ◯ Chewing (Smokeless) ◯ Cigar

NUMBER/FREQUENCY: _____

Number of years smoking:_____Number of years since quitting:_____

ALCOHOL USE: NO____YES____ TYPE: _____ FREQUENCY: _____

DENTAL HISTORY

1. What is your chief complaint? _____
2. Circle all that apply: Do your gums bleed? Are they sore/tender? Are your teeth loose? Do you clench/grind teeth? Does your jaws pop? Are you sensitive to hot/cold/sweets?
3. Do you get regular dental care? NO____YES___Date of last visit:_____ Cleaning frequency:_____
4. Have you ever been told you have periodontal (gum) disease? NO____YES____ If yes, have you ever been treated for it? NO _____YES____ If so, when and by whom?_____
5. Do you wear a night guard or any dental appliance for TMJ issues?_____
6. Have you ever had Botox® treatment for TMJ issues or headaches, or would you be interested in learning about this treatment option?_____
7. Do you use a sleep apnea machine? NO____YES____

Please feel free to make any comments about your general or oral health which was not covered in this medical history that you want to add or that may influence our treatment of you: _____

_____

Please notify our office immediately if you cannot keep your appoint time at least 24 hours in advance. If you fail to notify us or fail to show, there will be a charge depending on the appointment that was scheduled. Our entire staff strives to provide you with the best possible dental care in a courteous and efficient manner. If there are any problems relating to the care you receive or not receive, please let us know. It is only by our awareness that we are able to correct them and clarify any misunderstandings.

_____I acknowledge I received a copy of this office's Notice of Privacy Practices.

Signed: _____

Date: _____