# Hanford Family Dental Center

GENERAL AND COSMETIC DENTISTRY FOR ENTIRE FAMILY

Nikunj Raiyani D.D.S., P.C.
869 W Lacey Blvd Suite 101, Hanford CA 93230

Thank you for your visit today. We appreciate you trusting us to care for your dental health, and are pleased to welcome you to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask –we will be glad to help. We look forward to working with you.

## PATIENT INFORMATION

Who may we thank for referring you here? _____

Appointment preference ☐Morning ☐Afternoon

Name you prefer to called by: _____

Legal Name: _____

Address: _____

City, State, Zip: _____

Home phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

SSN: _____

Driver License: _____

Date of Birth: _____

Male/ Female

Spouse/parent Name: _____

Full time Student: Yes No

School: _____

Grade: _____

Occupation: _____

Your Employer: _____

In Case of emergency who should be notified: _____

Emergency Contact phone: _____

## RESPONSIBLE PARTY

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____SSN:_____

Address: ☐ Same as above.

Street: _____City, State, Zip: _____

## YOUR APPOINTMENT TODAY

1. Are you having pain or discomfort at this time? ☐ Yes ☐ No
2. Are you extremely nervous about dental treatment? ☐ Yes ☐ No
3. Do you need premedication before your dental treatment? ☐ Yes ☐ No

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# MEDICAL HISTORY

1. Name of your physician_____Phone #_____
2. Are you now under Physician care? ☐ Yes ☐ No
   If Yes, For What?_____
3. Are you taking any medications, drugs or pills? ☐ Yes ☐ No
   If yes, please list: _____for_____
   _____for_____
   _____for_____
4. Have you ever taken Phen-Fen or Redux? ☐ Yes ☐No
5. Have you ever taken Fosamax? ☐ Yes ☐No
6. Are you taking Aspirin daily? ☐ Yes ☐No
7. Any serious illness or hospitalization? ☐ Yes ☐No
   If yes please explain: _____
8. Are you allergic to any of the following?

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Codeine | ☐ | ☐ | Erythromycin | ☐ | ☐ | Mepivacaine | ☐ | ☐ |
| Aspirin | ☐ | ☐ | Penicillin | ☐ | ☐ | Carbocine | ☐ | ☐ |
| Latex | ☐ | ☐ | Tetracycline | ☐ | ☐ | Lidocaine | ☐ | ☐ |
| Novacaine | ☐ | ☐ | Jewelry/Metals | ☐ | ☐ | Others | ☐ | ☐ |

9. Indicate which of the following you had or have at present. Check "Yes" or "No" to each item.

| | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Heart Failure | ☐ | ☐ | Kidney Trouble | ☐ | ☐ | Hepatitis B | ☐ | ☐ |
| Heart Disease/Attack | ☐ | ☐ | on kidney Dialysis | ☐ | ☐ | Hepatitis C | ☐ | ☐ |
| Angina Pectoris | ☐ | ☐ | Ulcers | ☐ | ☐ | Venereal Disease | ☐ | ☐ |
| Congenital Heart Disease | ☐ | ☐ | Diabetes | ☐ | ☐ | A.I.D.S. | ☐ | ☐ |
| Heart Murmur | ☐ | ☐ | Hypoglycemia | ☐ | ☐ | H.I. V. Positive | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | Thyroid problems | ☐ | ☐ | Cold sores | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ | Glaucoma | ☐ | ☐ | Blood Transfusions | ☐ | ☐ |
| Heart Pacemakers | ☐ | ☐ | Cosmetic Surgery | ☐ | ☐ | Hemophilia | ☐ | ☐ |
| Mitral Valve prolapse | ☐ | ☐ | Emphysema | ☐ | ☐ | Anemia | ☐ | ☐ |
| Artificial Heart Valve | ☐ | ☐ | Chronic Cough | ☐ | ☐ | Sickle Cell Disease | ☐ | ☐ |
| Heart Surgery | ☐ | ☐ | Tuberculosis | ☐ | ☐ | Bruise Easily | ☐ | ☐ |
| Rheumatic Fever | ☐ | ☐ | Asthma | ☐ | ☐ | Liver disease | ☐ | ☐ |
| Arthritis | ☐ | ☐ | Allergies or Hives | ☐ | ☐ | Yellow Jaundice | ☐ | ☐ |
| Cortisone medicine | ☐ | ☐ | Sinus Trouble | ☐ | ☐ | Epilepsy/Seizures | ☐ | ☐ |
| Drug Addiction | ☐ | ☐ | Radiation Therapy | ☐ | ☐ | Fainting Spells | ☐ | ☐ |
| Stroke | ☐ | ☐ | Chemotherapy | ☐ | ☐ | Nervousness | ☐ | ☐ |
| Artificial Joints | ☐ | ☐ | Hepatitis A | ☐ | ☐ | Mental disorders | ☐ | ☐ |

10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐No
    If yes, Please Explain:_____

FOR WOMEN ONLY:
Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____
Are you nursing? ☐ Yes ☐No Are you taking birth control pills? ☐ Yes ☐ No

CONSENT:
I agree to comply with the policies of this office. Permission is granted to the Doctors at Hanford Family Dental Center to perform procedures including the giving of anesthetics and taking of x-rays, which may be necessary for my dental treatment.

☞ Patient name:_____Signature:_____Date:_____
(Guardian if patient is minor)
Doctor's initial: _____Date:_____