M. Ihsan Kayali, D.D.S
Periodontics & Implants Specialist

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San Dimas, CA 91773
(909) 599-9510

219 E. Badillo St.
Covina, CA 91723
(626) 966-9971

Date _____

Patient information

First Name _____ M.I.___ Last Name _____ NickName _____

Sex _____ D.O.B _____ Age _____ SSN _____ Driver's Lic # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

St. Address _____ City _____ State _____ Zip _____

Home Tel (_____)_____ Cell (_____)_____ E-mail _____

Are you a Student? ☐ Yes ☐ No School Name/Address _____

Have you ever been a patient of our practice? ☐ Yes ☐ No

Dentist _____ Medical Doctor _____ Referred By _____

Name of the nearest relative not living with you _____ Relation _____ Tel (_____) _____

Employer _____ Title_____ Tel (_____) _____

Personal Payment Type ☐ Cash ☐ Check ☐ Credit Card

In case of an emergency, please contact _____ Tel (_____) _____ Relation _____

Who will be responsible for your account (If self, please skip to the next section)

☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other _____

Name_____ SSN# _____ D.O.B _____ Age _____

Tel (_____) _____ Driver's Lic # _____ Email _____

St. Address _____ City _____ State _____ Zip_____

Spouse or other/guardian information (If different from above)

Name_____ SSN# _____ D.O.B _____ Age _____

Tel (_____) _____ Driver's Lic # _____ Email _____

St. Address _____ City _____ State _____ Zip_____

Insurance information

Primary Insurance Company

Insurance Type ☐ Dental ☐ Medical

Insurance Company Name _____

St. Address _____

_____ Tel ( ) _____

Group No _____

Group Name _____

Subscriber _____

Relationship _____ SSN _____

I.D. Number _____

D.O.B _____

Secondary Insurance Company

Insurance Type ☐ Dental ☐ Medical

Insurance Company Name _____

St. Address _____

_____ Tel ( ) _____

Group No _____

Group Name _____

Subscriber _____

Relationship _____ SSN _____

I.D. Number_____

D.O.B _____

Medical History

First and last name initials

Are you under the care of a physician □ Yes □ No Height_____ Weight_____ Are you in good health ☐ Yes ☐ No

Have you had any illness, operations, or have you been hospitalized in the past five years? □ Yes □ No ?

Do you have, or have you had, any of the following diseases medical conditions, or procedures? If yes please specify

☐	Are you immunosuppressed? (possibly from transplant surg)	□	AIDS	□	Are you on a diet
		□	Anemia	□	A history of alcohol abuse
□	A history of drug abuse	□	Asthma	□	Arthritis / Joint disease
□	Are you on dialysis	□	Bruise easily	□	Allergies or Hives
□	Abnormal bleeding	□	Blood disorder	□	Bleeding tendency
□	Bladder disease	□	Do you smoke	□	Blood transfusion
□	Bronchitis / Chronic cough	□	Delay in healing	□	Cardiac pacemaker
□	Chest pain / Angina pectoris	□	Diabetes	□	Convulsions
□	Contagious diseases	□	Emphysema	□	Chronic fatigue/ Night sweat
□	Difficulty climbing stairs	□	H.I.V.	□	Do you use chewing tobacco
□	Damaged heart valves	□	Heart murmur	□	Eye disease / Glaucoma
□	Epilepsy or seizures	□	Heart attack(s)	□	Fainting spells
□	Hay fever / Sinus problems	□	Heart surgery	□	Gallbladder Trouble
□	Irregular heartbeat	□	Hepatitis	□	High blood pressure
□	Infectious mononucleosis	□	Kidney disease	□	Low blood pressure
□	Jaundice / Liver disease	□	Nervousness	□	Immune system problems (possibly from Med./Surg.)
□	Low blood sugar	□	Osteonecrosis	□	
□	Mental health problems	□	Rheumatic fever	□	Malignant hyperthermia
□	Radiation / Chemotherapy	□	Stroke	□	Mitral valve prolapse
□	Respiratory problems	□	Scarlet fever	□	Osteoporosis / Osteopenia
□	Snoring / Sleep apnea	□	Swollen ankles	□	Sexually transmitted diseases
□	Thyroid disease	□	Stomach ulcers	□	Tumor or growth
□	Psychiatric treatment	□	Tuberculosis		

Medication

Are you now taking or have you taken :

□ Yes	□ NO	Pain killers (including aspirin)	□ Yes	□ NO	Anxiety pills	□ Yes □ NO	Diet pills
□ Yes	□ NO	Any bone density medication or bisphosphonates (Aredia, Zometa, Fosamax, Actonel)	□ Yes	□ NO	Muscle relaxers	□ Yes □ NO	Blood thinners (Coumadin, Aspirin, Advil)
			□ Yes	□ NO	stimulants		
			□ Yes	□ NO	Insulin	□ Yes □ NO	Tranquilizers
□ Yes	□ NO	Antidepressants	☐ Other, please specify				

Allergies

Are you allergic to/or had a reaction to:

□ Yes	□ NO	Local aneshetic (numbing med.)	□ Yes	□ NO	Latex	□ Yes □ NO	Sodium pentothal
□ Yes	□ NO	Valium or other tranquilizers	□ Yes	□ NO	Penicillin	□ Yes □ NO	Codeine or other narcotics
□ Yes	□ NO	Sulfites	□ Yes	□ NO	Soy		
□ Yes	□ NO	Aspirin	□ Yes	□ NO	Eggs / Yolks		

Please list any other medications or antibiotics you are allergic to:

Please list any allergies other than drug allergies:

First and last name initials

X_____

Questions 1-4 below for women only:

(please note that antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult with your physician/gynecologist for assistance regarding additional methods of birth control)

1) Is there a possibility of pregnancy? □ Yes □ No

2) Expected delivery date: _____

3) Are you nursing? □ Yes □ No

4) Are you taking birth control pills? □ Yes □ No

Dental Information

Reason for today's visit _____ Are you in pain? □ Yes □ No How long? _____

Please indicate any of the following problems by checking off the corresponding box:

□ Discomfort, clicking, or popping in jaw	□ Stained teeth	□ Lost / Broken filling(s)
□ Difficulty closing your jaw	□ Locking jaw	□ Loose / Shifting teeth
□ Difficulty opening your jaw	□ Bad breath	□ Food caught in between teeth
□ Burning tongue / lips	□ Toothache	□ Swelling / Lumps in mouth
□ Teeth grinding / clenching	□ Ringing in ears	□ Red, swollen, or bleeding gums
□ Broken / Chipped tooth	□ Gum disease	□ A removable dental appliance
□ Prolonged bleeding from an injury / Extraction	□ Recent infection or sore throat	□ Blisters / Sores in or around the mouth

My teeth are sensitive to: □ Hot □ Cold □ Sweets □ Biting

Other, please mention _____

Last Dental exam _____

How many times a day do you brush? _____ How many times a week do you floss? _____

How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best) Would you like a whiter teeth? □ Yes □ No

What type of toothbrush bristles do you use? □ Soft □ Medium □ Hard

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: **Reviewed by:** **Date:**

(Parent of Guardian if minor)

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any Procedure or surgery you may require will be given to you upon request. If you have any dental and / or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitue for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: **Date:**

(Parent of Guardian if minor)

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me

Signature of patient: **Date:**

(Parent of Guardian if minor)

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: **Date:**

(Parent of Guardian if minor)

Update / Changes _____

Signature of patient: **Date:**

First and last name initials

X_____