

# SOLANA SMILES

## AZITA VAKILI, DMD

530 Lomas Santa Fe, #3  
Solana Beach, CA 92075  
(858) 481-5210

**Patient's**

**Name**

**Birth date**

**Age**

**Sex:**

**M F**

<b>Home Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Home Phone #</b>	<i>Please Circle One:</i>		<b>Your Soc Sec. #</b> ( is not necessary if paying at the time of service)
<b>Work Phone #</b>			
<b>YOUR cell phone #</b>			
<b>Your Employer</b>	Single, Married, Separated, Widow		
<b>Occupation</b>			

**Are you a full time student?**

*If patient is minor we need:*

Yes No

*Mother's Name & Birth date*

*Father's Name & Birth date*

**Person paying this bill**

**YOUR Driver's License Number**

**Name of spouse ( or parent if minor)**

**YOUR E-mail address**

**Spouse's ( or parent's) employer**

**Spouse's Soc. Sec. #**

**Work phone #**

**EMERGENCY INFORMATION**

*Name, Address, & Telephone of  
A relative not living with you:*

**How did you hear about our office?**

**Reason for your visit today?**

DENTAL INSURANCE INFORMATION (Primary Carrier)	If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)
<b>Insured's name</b>	<b>Insured's name</b>
<b>DOB</b>	<b>DOB</b>
<b>SS#</b>	<b>SS#</b>
<b>Insured's employer</b>	<b>Insured's employer</b>
<b>Insurance Co</b>	<b>Insurance Co</b>
<b>Insurance Co Address</b>	<b>Insurance Co Address</b>
<b>Phone #</b>	<b>Phone #</b>
<b>Group #</b>	<b>Group #</b>
<b>Policy #</b>	<b>Local #</b>

**Dental History**

Please check the following : YES NO

- Sensitivity (hot, cold, sweet)  
Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain
- Mouth ulcers or cold sores
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath

**Do you have or have you had any of the following?**

- Dentures
- Partial dentures
- Braces
- Gum treatments

**Please share the following dates:**

- Your last cleaning \_\_\_\_\_ / \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_ / \_\_\_\_\_
- Your last complete X-Rays \_\_\_\_\_ / \_\_\_\_\_

Name of Previous Dentist \_\_\_\_\_

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

Phone Number \_\_\_\_\_

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

**If you could whiten your teeth for a cost anyone could afford, would you do it?**

**Do you smoke or use chewing tobacco?**

How much? For how long?

**If I could change my smile, I would:**

- Make my teeth whiter
- Make my teeth straighter
- Close spaces
- Replace metal fillings with tooth colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

**On a scale of 1 – 10, with 10 being the highest rating:**

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

**Why did you leave your previous dentist?**

\_\_\_\_\_

What is the most important thing to you about your dental visit today? \_\_\_\_\_

## MEDICAL HISTORY

**Please check any of the following that apply to you:**

- |                           |                      |                         |                            |
|---------------------------|----------------------|-------------------------|----------------------------|
| AIDS/HIV Positive         | Diabetes             | Heart Pacemaker         | Recent Weight Loss         |
| Anemia                    | Drug Addiction _____ | Heart Trouble/Disease   | Renal Dialysis             |
| Angina                    | Emphysema            | Hemophilia              | Rheumatic Fever            |
| Artificial Heart Valve    | Epilepsy or Seizures | Hepatitis A B or C      | Rheumatism                 |
| Artificial Joints         | Excessive Bleeding   | Herpes                  | Scarlet Fever              |
| Asthma                    | Excessive Thirst     | High/Low Blood Pressure | Shingles                   |
| Blood Disease             | Fainting             | Hives or Rash           | Sinus Trouble              |
| Blood Transfusion         | Spells/Dizziness     | Hypoglycemia            | Stomach/Intestinal Disease |
| Breathing Problems        | Frequent Cough       | Irregular Heart Beat    | Thyroid Disease            |
| Bruise Easily             | Frequent Headaches   | Kidney Problems         | Tuberculosis               |
| Cancer/Chemotherapy       | Genital Herpes       | Leukemia                | Tumors or Growths          |
| Chest Pains               | Glaucoma             | Liver Disease           | Ulcers                     |
| Cold Sores/Fever Blisters | Hay Fever            | Mitral Valve Prolapse   | Venereal Disease           |
| Congenital Heart Disorder | Heart Attack/Failure | Psychiatric Care        | Other:                     |
| Convulsions               | Heart Murmur         | Radiation Treatment     |                            |

**FOR WOMEN ONLY:**

- Birth Control Pills
  - Breast-feeding
  - Pregnant
- Duration \_\_\_\_\_

**Are you allergic to any of the following**

- |            |            |        |
|------------|------------|--------|
| Aspirin    | Metal      | Other: |
| Penicillin | Latex      |        |
| Codeine    | Local      |        |
| Acrylic    | Anesthetic |        |

**Family Physician:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

**Is there any other Medical or Dental Information we should know about?** \_\_\_\_\_

**Are you under a physician's care? For what?**

**Explain:** \_\_\_\_\_

**Are you currently taking any Prescription**

**Medication? Yes No**

**What?** \_\_\_\_\_

**Are you currently taking Aspirin? Yes No**

**Are you currently taking any Supplements (Synthetic or Natural) Yes No**

**What?** \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor Signature

\_\_\_\_\_  
Date