Pasadena
Microscopic
Endodontics

Welcome

Armen A. Hartoonian, DMD, MSD, Inc.
Practice Limited to Micoscopic Endodontics

Home Phone _____

Date _____ Cell Phone _____

PATIENT INFORMATION

Name _____ Soc.Sec. # _____
Last Name First Name Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contract # _____ Group _____ Subscriber # _____

Names of other dependents under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date

DENTAL HEALTH HISTORY

(Confidential)

DENTAL HISTORY

Reason for Today's Visit (please describe) _____

_____

Referring Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

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

Y	N		Y	N		Y	N	
❑	❑	Bad breath	❑	❑	Grinding teeth	❑	❑	Sensitivity or pain to hot
❑	❑	Bleeding gums	❑	❑	Loose teeth or broken fillings	❑	❑	Sensitivity or pain to sweets
❑	❑	Clicking or popping jaw	❑	❑	Periodontal treatment	❑	❑	Sensitivity or pain when biting
❑	❑	Food collection between teeth	❑	❑	Sensitivity or pain to cold	❑	❑	Sores or growths in your mouth

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

Have you had any serious illnesses or operations? _____ If yes, describe _____

Have you ever had a blood transfusion? ❑ Yes ❑ No If yes, give approximate dates _____

Have you ever taken Phen-Fen, Redux or Pondimin? ❑ Yes ❑ No

(Women) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have or have had any of the following:

Y	N		Y	N		Y	N		Y	N	
❑	❑	AIDS	❑	❑	Cortisone Treatments	❑	❑	Hepatitis	❑	❑	Rheumatic Fever
❑	❑	Anemia	❑	❑	Cough, Persistent	❑	❑	High Blood Pressure	❑	❑	Scarlet Fever
❑	❑	Arthritis, Rheumatism	❑	❑	Cough up Blood	❑	❑	HIV Positive	❑	❑	Shortness of Breath
❑	❑	Artificial Heart Valves	❑	❑	Diabetes	❑	❑	Jaw Pain	❑	❑	Skin Rash
❑	❑	Artificial Joints	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Stroke
❑	❑	Asthma	❑	❑	Fainting	❑	❑	Liver Disease	❑	❑	Swelling of feet or Ankles
❑	❑	Back Problems	❑	❑	Glaucoma	❑	❑	Mitral Valve Prolapse	❑	❑	Thyroid Problems
❑	❑	Blood Disease	❑	❑	Headaches	❑	❑	Nervous Problems	❑	❑	Tobacco Habit
❑	❑	Cancer	❑	❑	Heart Murmur	❑	❑	Pacemaker	❑	❑	Tonsillitis
❑	❑	Chemical Dependency	❑	❑	Heart Problems	❑	❑	Psychiatric Care	❑	❑	Tuberculosis
❑	❑	Chemotherapy			Describe _____	❑	❑	Radiation Treatment	❑	❑	Ulcer/GI Problems
❑	❑	Circulatory Problems	❑	❑	Hemophilia	❑	❑	Respiratory Disease	❑	❑	Venereal Disease

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

Y	N		Y	N	
❑	❑	Aspirin	❑	❑	Tetracycline
❑	❑	Barbiturates (Sleeping Pills)	❑	❑	Jewelry / Metals
❑	❑	Codeine	❑	❑	Latex
❑	❑	Local Anesthetic	❑	❑	Sedatives
❑	❑	Penicillin	❑	❑	Other _____
❑	❑	Sulfa			_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____