Dr. Zahra Z. Alvandi, D.D.S. * 1744 Fry Rd, Houston, TX 77084 * Phone 281-492-8900

BRITER DENTAL

WELCOME

Thank you for selecting Briter Dental! To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you!

1) PATIENT INFORMATION

This appointment is for □ Yourself □ Your Child
Patient Full Name _____ Social Security # _____
Birth Date _____ Age _____ □ Male □ Female □ Single □ Married □ Other
Driver's License #_____ State_____ Exp Date _____
Address _____ City _____ State ____ Zip _____
Full Time Student _____ □ Yes □ No School Name_____
Employer _____ Occupation _____
Previous Dentist _____ Previous Dentist Phone_____
Current Physician _____ Current Physician Phone_____

2) TELEPHONE & EMAIL

Home Phone _____ Work Phone_____ Cell Phone_____
Email _____ Best time to call _____
In the event of an emergency, who should we contact?
Name_____ Relationship _____
Home Phone _____ Work Phone _____

3) RESPONSIBLE PARTY

Who is responsible for this patient
Full Name _____ Social Security # _____
Birth Date _____ Age _____ □ Male □ Female _____
Address _____ City _____ State ____ Zip _____
Employer _____ Occupation _____
Home Phone _____ Work Phone_____

4) INSURANCE INFORMATION

Dental Coverage □ Yes □ No
Insured's Name _____ Relation _____
Insured's Social Security # _____ Birth Date _____
Insurance Group # _____ Insurance Policy # _____
Insurance Co. Name _____ Insurance Co Phone _____

5) DENTAL HISTORY

Why have you come to the dentist today? _____
Date of last Dental Visit: _____
Do you require premedication before dental treatment? ..... Yes___ No___
Are you currently in pain? ..... Yes___ No___
Do your gums ever bleed?..... Yes___ No___
Have you ever had difficulties associated with any previous dental work? ..... Yes___ No___
Do you or have you ever experienced pain in your jaw joint (TMJ / TMD)?..... Yes___ No___
Have your tonsils or adenoids been removed? ..... Yes___ No___
Do you floss on a regular basis?..... Yes___ No___

6) MEDICAL HISTORY

Do you consider yourself in good medical health? ..... Yes___ No___
Have you had previous skin reactions to jewelry or know of an allergy to any metal?..... Yes___ No___
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?..... Yes___ No___
Have you been hospitalized or had a serious operation or illness within the last 5 years?..... Yes___ No___
Are you taking any medications?..... Yes___ No___
If so, please list here? _____
Are you allergic to any of the following?

- ☐ Penicillin
- ☐ Codeine
- ☐ Aspirin
- ☐ Lidocaine or Marcaine
- ☐ Nitrous oxide gas
- ☐ Iodine
- ☐ Dental anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Other: _____

Have you ever had any of the following medical problems? Please check those that apply:

- ☐ Abnormal bleeding
- ☐ Alcohol / Drug abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Cancer or Leukemia
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Ulcers
- ☐ Blood Disorders
- ☐ Implants
- ☐ Artificial Heart Valve
- ☐ Blood Transfusion
- ☐ Angina Pectoris
- ☐ Hepatitis A (Infectious)
- ☐ Yellow Jaundice
- ☐ Fainting or Dizzy Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack or Disease
- ☐ Heart Murmur / Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV Positive / AIDS
- ☐ Venereal Disease
- ☐ Tumors
- ☐ Heart Failure
- ☐ Cough
- ☐ Sickle Cell Disease
- ☐ Congenital Heart Lesions
- ☐ Hepatitis B (Serum)
- ☐ STD/ Syphillis, Gonorrhea
- ☐ Kidney Problems
- ☐ Liver Disease / Problems
- ☐ Low Blood Pressure
- ☐ Nervous Disorder
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Seizures or Epilepsy
- ☐ Shingles
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Stomach Problems
- ☐ Steroids
- ☐ Tuberculosis (TB)
- ☐ Bruise easily
- ☐ Cold Sores
- ☐ Scarlet Fever
- ☐ Psychiatric Treatment
- ☐ Other_____ _____

Women only:
Are you currently pregnant?..... Yes___ No___
If so, how many weeks? _____
Are you nursing ..... Yes___ No___
Are you taking birth control ..... Yes___ No___

7) REFERRAL INFORMATION

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Internet ☐ Pass by
☐ Yellow Book Katy ☐ ATT Yellow Pages ☐ Consolidated Phone book ☐ Other:_____
Name of person or office referring you to our practice: _____

8) ACKNOWLEDGEMENT & AUTHORIZATION

The undersigned hereby authorized Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorized Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated with (name of Patient) _____and further authorize and consent that Doctor choose and employ such as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I certify that I have read and understand the above. I acknowledge that my questions have been answered truthfully and to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.
SIGNATURE _____ DATE _____

DOCTOR'S SIGNATURE _____DATE _____