Dr. Aveed Samiee
25500 Rancho Niguel Rd. Suite 170
Laguna Niguel, CA 92677
949-421-5033

PATIENT INFORMATION FORM

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

Preferred Name?	Birth date: / /	Social Security No.

Street address:	Cell Phone no. ( )	Home phone no. ( )

City:	State:	ZIP Code:

Email Address:	Referred by?

Primary Physician:	Phone Number:
Pharmacy:	Phone Number:
Previous Dentist:	Phone Number:
Emergency Contact:	Phone Number:

INSURANCE INFORMATION

Provider:	Group no.:	Policy no.:

Subscriber's name:	Subscriber Date of Birth / /	Subscriber ID or SSN

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for any balance. I also authorize OC Lifetime Dental or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

MEDICAL HISTORY

List of Hospitalizations or Surgeries

Date:	Reason:
Date:	Reason:
Date:	Reason:

List of Medications:

MEDICAL HISTORY

Current or History of the following:	**Females:**
❑ Yes ❑ No Blood Thinners	☐ Pregnant
❑ Yes ❑ No Bisphosphonates (Boniva, Fosamax)	☐ Nursing
	☐ Oral Contraception

MEDICAL CONDITIONS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

CARDIOVASULAR	**BLOOD DISORDERS**		**STEROID / AUTO IMMUNE**	
❑ Yes ❑ No Heart Attack	❑ Yes ❑ No	HIV or AIDS	❑ Yes ❑ No	Steriod Supplement
❑ Yes ❑ No Heart Murmur	❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Lupus
❑ Yes ❑ No Pacemaker	❑ Yes ❑ No	Bleeding Disorders	Other:	
❑ Yes ❑ No Stroke	❑ Yes ❑ No	Leukemia	**PSYCHIATRIC**	
❑ Yes ❑ No Chest Pain	Other:		❑ Yes ❑ No	Depression
Other:	**CANCER**		❑ Yes ❑ No	Schizophrenia
LIVER/KIDNEY	❑ Yes ❑ No	Chemotherapy	Other:	
❑ Yes ❑ No Hepatitis	❑ Yes ❑ No	Radiation		
❑ Yes ❑ No Liver Disease	Other:			
❑ Yes ❑ No Dialysis	**MISCELLANEOUS**			
❑ Yes ❑ No Kidney Disease	❑ Yes ❑ No	Joint Replacement	❑ Yes ❑ No	Hyperthyroid
Other:	If yes when?		❑ Yes ❑ No	Hypothyroid
DIABETES	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Osteoporosis
❑ Yes ❑ No Type 1	❑ Yes ❑ No	COPD	❑ Yes ❑ No	Head/ Neck Trauma
❑ Yes ❑ No Type 2	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No	Sleep Apnea
Other:	❑ Yes ❑ No	Epilepsy / Seizures	❑ Yes ❑ No	Asthma
	❑ Yes ❑ No	Herpes / STD's	Other:	
ALLERGIES				
❑ Yes ❑ No Aspirin	❑ Yes ❑ No	Sulfa Drug	❑ Yes ❑ No	Latex
❑ Yes ❑ No Clindamycin	❑ Yes ❑ No	Vicodin	❑ Yes ❑ No	Motrin
❑ Yes ❑ No Codeine	❑ Yes ❑ No	Erythromycin	❑ Yes ❑ No	Penicillin
❑ Yes ❑ No Narcotics	❑ Yes ❑ No	Dental Anesthesia	Other:	
❑ Yes ❑ No Doxycycline	❑ Yes ❑ No	Iodine	Other:	

AUTHORIZATION FOR DENTAL TREATMENT AND RELEASE TO INSURANCE

I authorize and give consent to Dr. Samiee and her staff to perform dental treatment, including but not limited to: local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embody a certain risk. I certify that I have read and understand the above information to the best of my knowledge. The questions above have been answered accurately. I understand that providing incorrect information can be dangerous to my health and that Dr. Aveed Samiee and staff are not responsible for any information that was omitted from the form.

Patient/Guardian signature *Date*

For Completion by Dentist: