MADJID MATIN DMD, LLC
PERIODONTICS AND IMPLANT DENTISTRY
5530 WISCONSIN AVENUE
SUITE 1110
CHEVY CHASE, MD 20815
TEL: 301.656.6424
FAX: 301.656.6425

Patient Information (please print) All personal information is kept strictly confidential

Title _____
First Name _____ MI ____ Last Name _____

Date of Birth _____ Social Security Number _____

Phones: Home _____ Work _____ Cell _____

Fax _____ Email _____ Contact preference _____

Address _____ Apt # _____

City _____ State _____ Zip code _____

Employer _____ Occupation _____

Emergency Contact/Guardian _____ Phone _____

Primary Physician _____ Phone _____

Pharmacy/location _____ Phone _____

General Dentist _____ Phone _____

Date of Last Dental Cleaning _____ Any pain/clicking in jaw (TMJ) _____

Are having pain/discomfort, if so, where?_____

Have you been treated for periodontal disease in the past? _____

What dental concerns/treatment are you seeking today?

_____

Who may we thank for referring you _____ Phone _____

Please read and initial the following:

_____I authorize the release of any information concerning my healthcare, advice and treatment to another dentist, doctor and/or insurance company for benefits.

_____I understand that a fee may be charged for broken appointments as well as cancellations with less than 24 hours notice.

_____I understand that all professional services are charged directly to the patient and I am responsible for full payment of all fees at time of treatment.

This office does not participate with any insurance carriers. However, we will provide claim forms for you to submit for reimbursement, just present your insurance card to the front desk.

*** PLEASE TURN PAGE OVER – CONTINUED ON THE BACK ***

Medical History

Do you have to premedicate with antibiotics before dental procedures? **YES NO**
If yes, what medication/dose: _____

Are you allergic or have had an adverse reaction/sensitivity to any medications? **YES NO**
If yes, list what/reaction: _____

Please list ALL medications you are currently taking (including baby aspirin, birth control)

_____

Have you ever been hospitalized/major surgery? **YES NO**
If yes, list reason/procedure and dates:

_____

If female, are you pregnant? **YES NO** if yes, what trimester _____

Do you or did you ever have any of the following? PLEASE CHECK IF YES

Asthma ☐ Sinus problems ☐ Tuberculosis ☐ Rheumatic fever ☐ Artificial joints ☐

Arthritis or rheumatism ☐ Alcoholism ☐ Epilepsy/seizures ☐ Nervous or mental disorders ☐

Diabetes ☐ High blood pressure ☐ Low Blood Pressure ☐ Stroke ☐ Anemia ☐

Kidney problems ☐ Blood disease ☐ Blood transfusion ☐ Excessive/prolonged bleeding ☐

Slow healing of wound/incision ☐ Goiter/gland/thyroid problems ☐ Liver/gall bladder problems ☐

Stomach problems/ulcers ☐ Yeast infection of mouth ☐ Fever blisters/cold sores ☐

Heart murmur ☐ Prolapsed valve ☐ Pacemaker ☐ Artificial valve/stent ☐

Heart: disease ☐ attack ☐ bypass ☐ angina ☐

Hepatitis or carrier of? **YES NO** if yes what type _____

To the best of your knowledge, are you HIV+ or have AIDS? **YES NO**

Sexually transmitted disease (including herpes)? **YES NO**

Do you smoke? **YES NO** if yes how much _____

Do you chew tobacco/dip snuff? **YES NO** if yes how much _____

Cancer? **YES NO** if yes type? _____ are you in treatment with radiation and/or chemotherapy? _____ or cured/in remission? _____

Any other medical conditions not listed? _____

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

_____

Patient Signature **Date**

Office use only: BP _____ *P* _____
Notes: