MAS'OOD CAJEE, DDS, MPH
NABEEL CAJEE, DDS, MICOI
NA'EEL CAJEE, DMD, MTS

WELCOME! ¡BIENVENIDOS!
أهلا بك! ਸਤ ਸ੍ਰੀ ਅਕਾਲ! سلام!

Today's Date:________________

Power to bite. Confidence to smile.
Our goal: to help you confidently smile & bite apples…now and when you're 100+ years old.

>> ABOUT YOU

Name ____ **I prefer** to be called ________________
(Last) (First) M.I.
Birthdate _____/_____/_______ **Age** ____________ **Gender** Male______ Female______
O Minor O Single O Married O Divorced O Widowed O Separated O Partnered for ____ years

Home Address ____
Street/P.O. Box City,State Zip
Home Phone # ______________________________ Work Phone # ______________________
Mobile Phone # ____________________________ Receive text or voice messages? Yes____ No____
E-Mail ___________________________________ Receive email reminders? Yes____ No____
What is the best time of day to call? O 7am-9am O 9am-12pm O 12pm-5pm O 5pm-8pm
Social Security # _________-_________-___________ **Driver's License #** ______________________
Employer/School _________________________ Occupation ___________________________
Do you have children? If Yes, how many?_________________________
Who can we thank for referring you? *(Our average patient refers at least 3 friends or family.)*
O Friend/Family Name: ________________ O Google O Yelp O Other: ________________

>> PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party Name:______________________________ Relation to patient:______________________
Address (If different from above):____
Phone:_(______)______________________________ Email: ____________________________________

>> INSURANCE INFORMATION

PRIMARY INSURANCE
Insurance Company_________________________Group #_______________________________
Insured Name: _______________________ **SS#**:______________________ **Birthdate**:__________
Employer: ______________________________ Relation to patient:______________________

SECONDARY INSURANCE
Insurance Company ___________________Group #_______________________________
Insured Name: _______________________ **SS#**:______________________ **Birthdate**:__________
Employer: ______________________________ Relation to patient:______________________

>> IN EVENT OF EMERGENCY

Contact Name:__________________________ Relationship: _______________ Home Phone #:______________
Mobile Phone #:________________________ Other Phone #:________________________

>> DENTAL HISTORY

1. **Why are you here today?**

   ____

2. How many times a day do you **brush**?__________ My **toothbrush** is: O ELECTRIC O MANUAL

3. How often do you **floss**? O DAILY O WEEKLY O SOMETIMES O NEVER

4. If you could change **one thing** about your smile, what would it be?

   ____

5. Are you interested in **straightening your teeth** in as little as 6 months? O YES O NO

6. Are you interested in **replacing any missing teeth**? O YES O NO

7. What **snacks** (food or drink) have you had in the **last 24 hours**?

   ____

8. Besides Water, Milk, Tea or Coffee, **what do you drink on a daily or weekly basis**?

   ____

9. What have you liked **most** about any dental office you've been to before?

   ____

10. What have you liked **least** about any dental office you've been to before?

    ____

11. Your **previous dentist**? **Date of last Dental Visit?**
    Dr.____________________ (Approximate Month/Year): ____________________

12. Do you use **tobacco products**? O DAILY O WEEKLY O SOMETIMES O NEVER

13. Do you drink **alcohol**? O DAILY O WEEKLY O SOMETIMES O NEVER

14. Do you drink **soda, sports or energy drinks**? O DAILY O WEEKLY O SOMETIMES O NEVER

FYI: Why do we ask about tobacco, alcohol, and other drinks?
*~ Tobacco is the leading cause of **tooth loss**.*
*~ Alcohol & tobacco cause **oral cancer & other cancers**.*
*~ Soda, sports & energy drinks are a leading cause of **cavities**.*

>> MEDICAL HISTORY

1. Your **Physician's Name**:_________________________________Your Preferred **Pharmacy**:__________________
2. Do you need **antibiotic premedication** before dental treatment? O YES O NO O I DON'T KNOW

3 Have you been **hospitalized** within the past 5 years? O YES O NO

IF YES, WHY? ____

4. Are you taking any **medication,** including non-prescription medicine? (Aspirin, Blood thinners, etc.)

PLEASE LIST: ____

____

5. Have you ever taken Actonel, Aredia, Bonefos, Boniva, Fosamax, Skelid, Zometa or any other **drugs** prescribed for **osteoporosis** or **metastatic bone cancer**? O YES O NO

6. **WOMEN ONLY:**

Are you taking **birth control pills**? O YES O NO Are you **breastfeeding**? O YES O NO

Are you **pregnant** or think you may be pregnant? O YES O NO If YES, what is your Due Date?____________

7. **Are you allergic to any of the following? Please circle all that apply.**

Aspirin	YES NO	Penicillin/Amoxicillin	YES NO	Sedatives	YES NO	Any Metals	YES NO
Jewelry	YES NO	Sulfa Drugs	YES NO	Codeine	YES NO	Iodine	YES NO
Latex	YES NO	Dental Anesthetics	YES NO	Barbiturates	YES NO		

8. **Do you have or have you had the following? Please circle all that apply.**

Abnormal Bleeding	YES NO	Artificial Bones/Joints	YES NO	Alcohol Abuse	YES NO	Allergies	YES NO
Anemia	YES NO	Angina	YES NO	Arthritis	YES NO	Asthma	YES NO
Artificial Valves	YES NO	Blood Disorder	YES NO	Congenital Heart	YES NO	Chemotherapy	YES NO
Cancer	YES NO	Chest Pain	YES NO	Cough, persistent	YES NO	Depression	YES NO
Diabetes	YES NO	Drug Abuse	YES NO	Difficulty Breathing	YES NO	Epilepsy	YES NO
Emphysema	YES NO	Fainting Spells	YES NO	Glaucoma	YES NO	HIV+/AIDS	YES NO
Headaches	YES NO	High Blood Pressure	YES NO	**Heart Disease**	YES NO	Hepatitis_____	YES NO
Herpes	YES NO	Jaw Pain	YES NO	Kidney Problems	YES NO	Low Blood Pressure	YES NO
Liver Disease	YES NO	Pacemaker	YES NO	Psychiatric Care	YES NO	Radiation Treatment	YES NO
Rheumatic Fever	YES NO	Seizures	YES NO	Sinus Problems	YES NO	Stroke	YES NO

9. Do you have or have you had any medical problems NOT listed on this form? O YES O NO

IF YES, PLEASE LIST: ____

>> ANNUAL UPDATE

Any changes in Medical History? YES NO
Date / Patient Signature:

____

Any changes in Medical History? YES NO
Date / Patient Signature:

____

Any changes in Medical History? YES NO
Date / Patient Signature:

____

Any changes in Medical History? YES NO
Date / Patient Signature:

____

Any changes in Medical History? YES NO
Date / Patient Signature:

____

Any changes in Medical History? YES NO
Date / Patient Signature:

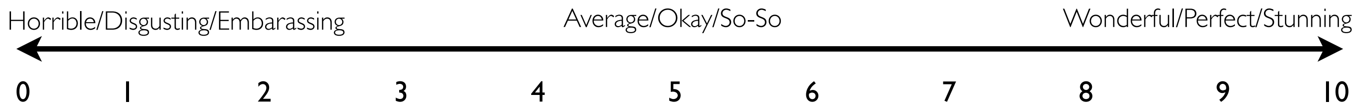
____

Any changes in Medical History? YES NO
Date / Patient Signature:

____

>> ABOUT YOUR TEETH & GUMS

How would you rate the health & appearance of <u>your</u> teeth & gums?
Please circle where you feel you are on a scale of 1 to 10. Thank you!



What do you feel would have to change for your teeth & gums to be a 10?
Please write your response in the box. Thank you!

>> AUTHORIZATION & RELEASE

- I certify that I have read and understand the above information to the best of my knowledge.
- The above questions have been accurately answered.
- I understand that providing incorrect information can be dangerous to my health.
- I authorize Dr. Cajee to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners.
- I authorize Dr. Cajee to obtain medical clearance and to share medical records in order to expedite treatment and assist in diagnosis.
- I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.
- I understand that my dental insurance carrier may pay less than the actual bill for services.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents.
- I understand that a copy of the HIPAA Notice of Privacy Practices is available on request.

X____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN

>> FOR OFFICE USE ONLY

Date / Doctor Signature	6 month update/ Date / Doctor Signature
6 month update/ Date / Doctor Signature	6 month update/ Date / Doctor Signature
6 month update/ Date / Doctor Signature	6 month update/ Date / Doctor Signature