

Welcome to Irvine Endodontics

Fay Mansouri, D.D.S. Endodontics and Microsurgery
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I have received a copy of the Privacy Policy according to HIPAA rules **X** _____

Patient Information

Date:		
Last:	First:	Middle Initial
HomePhone:	Work Phone: Ext:	Cell Phone:
SS#:	Date of Birth:	Drivers Lic.#
Address:	City:	Zip:
Email:	Occupation	Emergency #:

Dental Insurance Information

Subscriber Name: <small>(person responsible for account or Insurance)</small> Last name, First name		
SS#:	Date of Birth:	Relation to Patient: (circle one below)
Employer:	Telephone:	Self Spouse Parent life partner
Ins. Co:	Plan name:	Group #:

General Dentist Information

General Dentist's name:	Telephone
Address:	City: Zip:

Medications and Allergies

Current Medications: _____ _____	ALLERGIES	NONE	Vicodin
	Other:	Iodine	Latex
	Asprin	Anesthetics	Bleach
	Ibuprofin	Sulfa	Penicillin

Medical History

Have you ever had any of the following conditions or diseases:

		TMJ diag or pain		yes	no						
AID/HIV	yes	no	Diabetes	yes	no	Pacemaker	yes	no	For women only:		
Arthritis	yes	no	Drug Abuse	yes	no	Respiratory Disease	yes	no		Nursing	yes
Artificial Heart Valve	yes	no	Emphysema	yes	no	Rheumatic Fever	yes	no	Pregnant	yes	no
Artificial Joints	yes	no	Epilepsy	yes	no	Shortness of Breath	yes	no	Physician's Info:		
Asthma	yes	no	Murmur	yes	no	Sinus Trouble	yes	no			
Abnormal Bleeding	yes	no	Heart Disease	yes	no	Stroke	yes	no			
Blood Disease	yes	no	Hepatitis	yes	no	Thyroid	yes	no			
Cancer	yes	no	High Blood Pressure	yes	no	Tuberculosis	yes	no			
Chemotherapy	yes	no	Liver Disease	yes	no	Ulcer	yes	no			
Congenital Heart Issues	yes	no	Mitral Valve Prolapse	yes	no	Venereal Disease	yes	no			
Osteoporosis/Medication	yes	no	Ulcerative Cholitit	yes	no	Pancreatitis	yes	no			

Other: _____

Dr. Signature _____

Authorization:

I authorize the doctor and/or the staff to perform an examination and take x-rays for my teeth. I authorize my insurance company to pay the treating dentist or his or her dental group all available insurance benefits; otherwise, payable to me for services rendered. I authorize the use of this signature on all insurance submissions and also to release all information necessary to secure payment for services rendered at Irvine Endodontics. I authorize my dental records to be release to my General Dentist.

X Signature: _____

Date: _____