RAMBOD KAMRAVA, D.D.S.
PRACTICE LIMITED TO ENDODONTICS
5400 BALBOA BLVD., SUITE 327
ENCINO, CA 91316
818-981-8115

Patient Information and Dental History

Patient's Name _____ Date of Birth_____
Last First
Home Address_____
City_____ State_____ ZIP_____
Home Phone_____ Cell Phone _____
Which number is best to contact you? ( ) Home ( ) Cell
Whom can we thank for referring you? _____
Social Security #_____
Name of Responsible Party _____ Relationship _____
Responsible Party D.O.B _____ Name of Dental Plan _____
Responsible Party SS#_____ Group/Policy Number _____

I have received a copy of Rambod Kamrava, DDS HIPAA statement.

Signature_____**Date**_____

Endodontic History

Please answer the following questions to assist us in understanding and diagnosing your dental condition.

Reason for your visit: _____
How long has your tooth been bothering you? _____
Is there anything you do that causes your symptoms? (If yes, what?)_____
Is there anything you can do to relieve your symptoms? (If yes, what?)_____
Have you taken pain medication today? (Specify time and medication)_____
How would you rate your current symptom?

No Symptoms Most Severe

0 1 2 3 4 5 6 7 8 9 10

Description of Dental Pain

	Yes	No		Yes	No
Is the pain constant?	( )	( )	Do hot fluids/foods cause pain?	( )	( )
Does the pain come and go?	( )	( )	Do cold fluids/foods cause pain?	( )	( )
Does lying down cause your tooth to hurt?	( )	( )	Does cold relieve pain?	( )	( )
Is the tooth sore to touch/bite?	( )	( )	Does your pain wake you at night?	( )	( )
Do you have pain in your ears/temples?	( )	( )	Did your dentist tell you that you		
Has your tooth been worked on recently?	( )	( )	need a root canal?	( )	( )

Please provide us with any other information you feel is important _____

_____

Health History Questionnaire

Primary Care Physician _____

Has a physician treated you for any reason in the last two years? Yes( )No( )

If so, please specify: _____

Are you **Allergic** to any drugs or other substances? Yes( )No( )
If so, please specify

_____

Do you have an **Allergy** to Latex? Yes( )No( )
Have you ever experienced bleeding that was difficult to stop? Yes( )No( )
Are you taking any medications (including aspirin)? Yes( )No( )

If so, please list name of medication and reason for taking it:_____

_____

_____

Are you taking any type of Osteoporosis Medication? Yes( )No( )
If so, please list name of medication:_____

Please indicate **Yes or No** for any current and past diagnoses and/or any symptoms you currently experience:

	Yes	No
Previous Infective Endocarditis	( )	( )
Artificial Cardiac Valve	( )	( )
Congenital Heart Disease	( )	( )
If yes;		
Repaired? _____		
Date of Surgery? _____		
Shunt present? _____		
Residual Defects? _____		
Do you have any other heart valve condition or problem? _____		
_____		
_____		
Congestive Heart Failure	( )	( )
Heart Attack	( )	( )
High Blood Pressure	( )	( )
Shortness of Breath on Mild Exertion.....	( )	( )
Stroke	( )	( )
Pacemaker	( )	( )
Chest Pain on Mild Exertion	( )	( )
Sinus Trouble	( )	( )
Fainting	( )	( )
Anemia/Blood Disorders	( )	( )
Hepatitis	( )	( )
Jaundice	( )	( )
Liver Disease	( )	( )

	Yes	No
Diabetes	( )	( )
Kidney Disease	( )	( )
Asthma	( )	( )
Lung Disease	( )	( )
Difficulty Breathing	( )	( )
Tuberculosis	( )	( )
Epilepsy	( )	( )
Ulcers	( )	( )
Glaucoma	( )	( )
Thyroid/Parathyroid Disease	( )	( )
Tumors/Cancer	( )	( )
Radiation Therapy	( )	( )
Psychological Disorders	( )	( )
Nervous/Anxiety Disorders	( )	( )
Artificial Joints	( )	( )
Drug Dependency	( )	( )
HIV Positive, AIDS	( )	( )
Females:		
Are you Pregnant?	( )	( )
Are you Breast-feeding?	( )	( )

Is there any other condition or problem that you think we should know about?_____

_____

Do you allow Dr. Kamrava to use the radiographs and pictures from your case for his lectures and presentations?
( ) Yes ( ) No

Thank you *for taking the time to provide us with this essential information. It will be used to select the safest and most effective means to treat your dental symptoms. All information provided is confidential.*

_____ _____

Patients Signature (Parent or Guardian, if patient is a minor) **Date**