



St. Louis Office
777 S. New Ballas Rd, #116E
St. Louis, MO 63141
PHONE: 314-4BRACES
FAX: 314-997-7554
E-MAIL: info@smilesaintlouis.com

Lake Saint Louis Office
104 Brevo Plaza
Lake Saint Louis, MO 63367
PHONE: 636-561-4615
FAX: 636-561-9001
E-MAIL: farhadmoshiri_springfield@yahoo.com

Springfield Office
1320 East Kingsley, #B
Springfield, MO 65804
PHONE: 417-881-7490
FAX: 417-881-3993
E-MAIL: farhadmoshiri_springfield@yahoo.com

Patient Information

Name LAST FIRST MIDDLE
Email (Home) (Work)
Home Address STREET CITY/STATE ZIP
Home Phone Birthdate Age Social Security No.
School/Employer Hobbies/Interest
If patient is a minor, give parent or guardian's name
Names and ages of other children in your family
Whom may we thank for referring you to our office?
Family Dentist Date of Last Visit:
Primary Care Physician Date of Last Visit:

Responsible Party Information

Name LAST FIRST MIDDLE S M D W Marital Status
Email (Home) (Work)
Home Address STREET CITY/STATE ZIP
How long at this address? Home Ph Work Ph Cell Ph
Previous Address (if less than 3 years)
Social Security No. Birthdate Relationship to Patient

Other Responsible Party - Emergency Contact

Name Relationship to Patient
Email Phone
Employer No. Years Employed Birthdate

INSURANCE INFORMATION

Primary Dental Insurance Information

(this portion must be filled out completely)

Subscriber's Name _____ Subscriber's SSN No. or Alt. ID _____
Subscriber's Address _____ City _____ State _____ Zip _____
Email (Home) _____ Subscriber's Birthdate _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Phone _____

Secondary Dental Insurance Information

Subscriber's Name _____ Subscriber's SSN No. or Alt. ID _____
Subscriber's Address _____ City _____ State _____ Zip _____
Email (Home) _____ Subscriber's Birthdate _____
Insurance Company _____ Group No. _____ Local No. _____
Insurance Co. Address _____ Phone _____

Primary Medical Coverage (For TMJ patients)

Subscriber's Name _____ Subscriber's SS No. or Alt ID _____
Subscriber's Birthdate _____ Patient relationship to subscriber _____ Self _____ Child _____ Spouse _____
Employer Name and Address _____ Employer Phone _____
Insurance Company Name _____ Group No. _____
Medical Claim Billing Address _____ Phone _____
City/State _____ Zip _____

I authorize release of any information relating to coverage. I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me.

I understand that, where appropriate, credit bureau reports may be obtained.

Signature of Responsible Party (Parent's signature if minor) _____ Date _____

Please present your insurance card so that copies can be made. The benefits obtained from your carrier may be subject to change.

Medical and Dental History

Please circle Yes or No (if Yes, please fill in details)

- Yes No Are you taking any medication(s)? List _____
Yes No Is antibiotic required prior to dental work? _____
Yes No Are you allergic to any medication (s)? List _____
Yes No Do you have a history of a major illness? _____
Yes No Are you currently under the care of a physician for a specific illness? _____
Yes No Have you had any major operations (if so, when)? _____

Check any of the following for which you have been treated?

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Herpes | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Sore Throats | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Immune Deficiency | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Bone Disorders |
| <input type="checkbox"/> Ear Infections/Tubes | <input type="checkbox"/> Endocrine Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental/Psychological Disorders | |
| <input type="checkbox"/> Allergies/Latex/Other | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor/Cancer /Radiation/Chemotherapy | |
| <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis/Liver Problems | |

What concerns you most about your teeth? _____

Desired Goals of Orthodontic treatment? _____

Please circle Yes or No (if Yes, please fill in details)

- Yes No Have you or anyone in your family ever seen an orthodontist? If yes, who and when? _____
Yes No Have any other family members been treated in this office? _____
Yes No Have your wisdom teeth been removed? If, so when _____
Yes No Do you presently have any dental pain or sensitive to temperature or pressure? Explain _____
Yes No Do your gums bleed when you brush? Date of last cleaning appointment with general dentist _____
Yes No Are you a mouth breather? Yes No Do you have a snoring habit? _____
Yes No Have your tonsils and adenoids been removed? What age? _____
Yes No Have you had any type of thumb sucking/pacifier/nail biting or tongue habit? Until what age? _____
Yes No Do you have any speech problems? _____
Yes No Have there been any injuries to your face, mouth or teeth? Explain _____
Yes No Have there been any falling accidents or sport injuries? Explain _____
Yes No Have you been involved in any automobile accidents or received whiplash? Explain _____
Yes No Have you ever had sprained or broken bones? Explain _____
Yes No Do you get headaches? How many times per week? _____
Yes No Do you have facial or orbital pain? If so, where does it hurt? _____
Yes No Do you have jaw pain? Which side? _____
Yes No Do your teeth or jaws ever feel uncomfortable when you wake up in the morning? _____
Yes No Are you aware of clenching your teeth during the day or been told that you grind your teeth? _____
Yes No Do you have neck/shoulder/lower back pain? _____
Yes No Have you ever experienced chronic ringing or a feeling of fullness in your ears? _____
Yes No Do you have numbness in your fingers and/or toes? _____
Yes No Do you have clicking or popping of your jaw joints? Which? _____
Yes No Have you ever experienced open and/or closed lock? Explain _____
Yes No Have you ever had jaw and/or joint surgery? When? _____
Yes No Are you aware that some appointments will be during school/work hours? _____
If the patient is under age 16, height of parents. Mom _____ Dad _____ Patient _____

Female Patients only: Yes No Are you pregnant? Due Date _____

FARHAD MOSHIRI, D.M.D., M.S., P.C. and MAZYAR MOSHIRI, D.M.D., M.S., P.C.

777 S. New Ballas Rd., #116E

St. Louis, MO 63141

(314) 997-3999

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
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