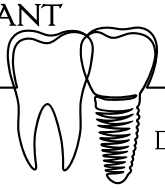
Patient Information

Akhrass Dental Implant & Cosmetic Center



DDS
FAAID
DABOI/ID

Name: _____
(First) (Middle) (Last)

Home Number: _____ Work Number: _____ Cell Phone: _____

Soc. Security #:_____ Birthdate:_____ Sex: M _____ F_____

Marital Status (Circle One): Single Married Widowed Divorced

Address: _____ City:_____State:_____ Zip:_____

Email:_____Employer:_____ Occupation:_____

Confirm my appointments by (Circle One): Text Message Email Phone Call

Parent's Name (if child):_____ Phone:_____ Employed By:_____

Spouse's Name:_____Phone:_____ Employed By:_____

Business Address:_____ Business Phone:_____

How Did You Hear About Our Office? _____

Reason For Visit: _____

Dental Insurance

Insured Name: _____

Home Number:_____ Work Number: _____Cell Phone:_____

Relationship To Patient:_____ Birthdate:_____ Soc. Security #:_____

Address: _____ City:_____ State: _____Zip: _____
(If Different Than Patient)

Dental Insurance Company:_____

Subscriber ID#:_____ Group ID#:_____

Additional Insurance

Is Patient covered by another Dental Insurance Plan: YES NO

Subscriber Name:_____ Relationship to Patient:_____

Soc. Security #:_____ Birthdate:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Address: _____ City:_____ State:_____ Zip:_____
(If Different Than Patient)

Dental Insurance Company:_____

Subscriber ID#:_____ Group #: _____

Financial Agreement & Authorization for Treatment

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me, and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within 30 days of billing date. In the event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/We agree to pay reasonable attorneys fees or such costs as the court determines proper. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original).

Signature of Patient or Legal Guardian:_____ **Date:** _____

Dental Health History

Patient Name:_____
(Last) (First) (Middle Initial)

Date of Last Dental Care:_____ Reason For Today's Visit:_____

Former Dentist:_____ Reason for Leaving: _____

How often do you floss? _____ How often do you brush?_____ Do you smoke? Y / N

Dental Health History

Do you take any herbs?_____ If yes, which ones?_____

Any side effects?_____ If yes, Please explain_____

Please check below if you have had any of the following:

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping jaw
- ❑ Food Collection between teeth
- ❑ Chipped or broken teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

Our office, **upon recommendation of the American Dental Association,** applies Topical Fluoride **every 6 months** to aid in the prevention of tooth decay, **through the age of 12 years. Most dental insurance companies will cover this procedure once a year.** Please Initial one of the choices below:

_____ **YES,** I understand and give my consent to the application of Fluroide **every 6 months.**

_____ **NO,** I refuse the application of Fluoride every 6 months as recommended by the American Dental Association.

Medical History

Physician's Name:_____ Date of last visit:_____

Have you had any serious illnesses or operations? Y / N

Describe:_____

Have you ever had a blood transfusion? Y / N

If yes, give approximate date:_____

Has your Physician ever told you that you need to take Antibiotics (Pre-Med) prior to having any dental work done due to recent joint replacement, heart surgery, etc. Y / N

(Women) Are you Pregnant? Y / N Nursing? Y / N Taking Birth Control Pills? Y / N

MEDICATIONS

List any and all medications you are taking:

_____

_____

_____

ALLERGIES

- ❑ Aspirin
- ❑ Barbiturates (sleeping pills)
- ❑ Codeine
- ❑ Local Anesthetic
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ LATEX
- ❑ Other

_____

Medical History

Check if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatment
- ❑ Cough, Persistent
- ❑ Cough up blood
- ❑ Diabetes
- ❑ Skin Rash
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems

Describe

_____

- ❑ Hemophilia/Excessive Bleeding
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Artificial Heart Valves
- ❑ Migraines
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Therapy
- ❑ Respiratory Disease
- ❑ Sleep Apnea
- ❑ Rheumatic Fever
- ❑ ADD/ADHD
- ❑ Seizures
- ❑ Reflux
- ❑ Stroke
- ❑ Swelling Feet/Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

The above information is complete and accurate 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 the completion of this form.

SIGNATURE: _____ DATE: _____