

# 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:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> BAD BREATH                    | <input type="checkbox"/> GRINDING TEETH                 | <input type="checkbox"/> SENSITIVITY TO HOT        |
| <input type="checkbox"/> BLEEDING GUMS                 | <input type="checkbox"/> LOOSE TEETH OR BROKEN FILLINGS | <input type="checkbox"/> SENSITIVITY TO SWEETS     |
| <input type="checkbox"/> CLICKING OR POPPING JAW       | <input type="checkbox"/> PERIODONTAL TREATMENT          | <input type="checkbox"/> SENSITIVITY WHEN BITING   |
| <input type="checkbox"/> FOOD COLLECTION BETWEEN TEETH | <input type="checkbox"/> SENSITIVITY TO COLD            | <input type="checkbox"/> SORES OR GROWTHS IN MOUTH |
| <input type="checkbox"/> CHIPPED OR BROKEN TEETH       |   |  |

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 FLUORIDE 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

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> ASPIRIN                       | <input type="checkbox"/> PENICILLIN  |
| <input type="checkbox"/> BARBITURATES (SLEEPING PILLS) | <input type="checkbox"/> SULFA DRUGS |
| <input type="checkbox"/> CODEINE                       | <input type="checkbox"/> LATEX       |
| <input type="checkbox"/> LOCAL ANESTHETIC              | <input type="checkbox"/> OTHER       |

\_\_\_\_\_

# MEDICAL HISTORY

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> AIDS                  | <input type="checkbox"/> EPILEPSY                      | <input type="checkbox"/> PACEMAKER            |
| <input type="checkbox"/> ANEMIA                | <input type="checkbox"/> FAINTING                      | <input type="checkbox"/> PSYCHIATRIC CARE     |
| <input type="checkbox"/> ARTHRITIS, RHEUMATISM | <input type="checkbox"/> GLAUCOMA                      | <input type="checkbox"/> RADIATION THERAPY    |
| <input type="checkbox"/> HIV POSITIVE          | <input type="checkbox"/> HEADACHES                     | <input type="checkbox"/> RESPIRATORY DISEASE  |
| <input type="checkbox"/> JAW PAIN              | <input type="checkbox"/> HEART MURMUR                  | <input type="checkbox"/> SLEEP APNEA          |
| <input type="checkbox"/> ARTIFICIAL JOINTS     | <input type="checkbox"/> HEART PROBLEMS                | <input type="checkbox"/> RHEUMATIC FEVER      |
| <input type="checkbox"/> ASTHMA                | DESCRIBE   | <input type="checkbox"/> ADD/ADHD             |
| <input type="checkbox"/> BACK PROBLEMS         | _____  | <input type="checkbox"/> SEIZURES             |
| <input type="checkbox"/> BLOOD DISEASE         | <input type="checkbox"/> HEMOPHILIA/EXCESSIVE BLEEDING | <input type="checkbox"/> REFLUX               |
| <input type="checkbox"/> CANCER                | <input type="checkbox"/> HEPATITIS                     | <input type="checkbox"/> STROKE               |
| <input type="checkbox"/> CHEMICAL DEPENDENCY   | <input type="checkbox"/> HIGH BLOOD PRESSURE           | <input type="checkbox"/> SWELLING FEET/ANKLES |
| <input type="checkbox"/> CHEMOTHERAPY          | <input type="checkbox"/> HIGH CHOLESTEROL              | <input type="checkbox"/> THYROID PROBLEMS     |
| <input type="checkbox"/> CIRCULATORY PROBLEMS  | <input type="checkbox"/> ARTIFICIAL HEART VALVES       | <input type="checkbox"/> TOBACCO HABIT        |
| <input type="checkbox"/> CORTISONE TREATMENT   | <input type="checkbox"/> MIGRAINES                     | <input type="checkbox"/> TONSILLITIS          |
| <input type="checkbox"/> COUGH, PERSISTENT     | <input type="checkbox"/> KIDNEY DISEASE                | <input type="checkbox"/> TUBERCULOSIS         |
| <input type="checkbox"/> COUGH UP BLOOD        | <input type="checkbox"/> LIVER DISEASE                 | <input type="checkbox"/> ULCER                |
| <input type="checkbox"/> DIABETES              | <input type="checkbox"/> MITRAL VALVE PROLAPSE         | <input type="checkbox"/> VENEREAL DISEASE     |
| <input type="checkbox"/> SKIN RASH             | <input type="checkbox"/> NERVOUS PROBLEMS              |   |

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: \_\_\_\_\_