Welcome to Our Practice

Please take a few minutes to fill out this form as completely as possible. If you have questions, we will be glad to help you. We look forward for this pleasant experience with you and / or child. And look forward to working with you in maintaining good dental health.

ABOUT YOUR CHILD

Today's Date: _____/_____/_____

Child's Name: _____

Child's Nickname: _____

☐ Male ☐ Female Birth date: ____/____/____ Age: _____

Address: _____

_____

CITY STATE ZIP

Child's Home Phone#: (_____)_____

School: _____

Hobbies / Sports: _____

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

General Dentist: _____

Dentist Office # (_____)_____

Address: _____

_____

CITY STATE ZIP

Who may we thank for referring you? _____

Who is accompanying this child today? _____

Name: _____

CHILD'S FAMILY INFORMATION

Mother's Name: _____

Date of Birth _____/_____/_____

Check if address is same as Child's ☐

Address: _____

_____

CITY STATE ZIP

Email address: _____

Cell # (____) _____ Work # (____) _____

Employer: _____ Job Title: _____

Father's Name: _____

Date of Birth _____/_____/_____

Check if address is same as Child's ☐

Address: _____

_____

CITY STATE ZIP

Email address: _____

Cell # (____) _____ Work # (____) _____

Employer: _____ Job Title: _____

PRIMARY INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Address: _____

Insurance Co. Phone#: (_____)_____

Group# (Plan, Local, or Policy#): _____

Policy Holder's Name: _____

Policy Holder's Birth date: _____/_____/_____

Relationship to Patient: _____

SS#: _____ Ins. ID# _____

Policy Holder's Employer: _____

Employers Address: _____

SECONDARY INSURANCE

Orthodontic Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Address: _____

Insurance Co. Phone#: (_____)_____

Group# (Plan, Local, or Policy#): _____

Policy Holder's Name: _____

Policy Holder's Birth date: _____/_____/_____

Relationship to Patient: _____

SS#: _____ Ins. ID# _____

Policy Holder's Employer: _____

Employers Address: _____

AUTHORIZATION AND RELEASE

I understand and certify that I, or my dependant(s), have insurance coverage with _____ and assign direct to Dr. Samy Ibrahim all insurance benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all services rendered. And also responsible for paying any co-payments/ deductibles and balances that my insurance does not cover. I authorize the use of this signature on all insurance submissions. I understand that there may be a need to consult with other health care providers. I authorize the release and use of my Protected Health information if required from another health care provider to Dr. Samy Ibrahim, until my treatment plan is completed.

_____ _____ _____

Responsible Party Signature **Relationship to Patient** **Date**

-PLEASE COMPLETE BOTH SIDES-

DENTAL HISTORY

Why are you here today? _____ Date of Last Dental Visit _____

Date of Last Dental x-rays _____How often do you brush _____ How often do you floss _____

Place a check on either "yes" or "No" for each of the following:

Bad Breath	□ Yes □ No	Food collection between teeth	□ Yes □ No	Pain around ear	□ Yes □ No
Bleeding Gums	□ Yes □ No	Grinding teeth	□ Yes □ No	Periodontal treatment	□ Yes □ No
Blisters on lip / mouth	□ Yes □ No	Gums swollen / tenderness	□ Yes □ No	Sensitivity to cold	□ Yes □ No
Burning sensation on tongue	□ Yes □ No	Jaw pain or tiredness	□ Yes □ No	Sensitivity to heat	□ Yes □ No
Chew on one side of mouth	□ Yes □ No	Lip or cheek biting	□ Yes □ No	Sensitivity to sweet	□ Yes □ No
Cigarette, pipe or cigar smoking	□ Yes □ No	Loose teeth or broken filling	□ Yes □ No	Sensitivity when biting	□ Yes □ No
Clicking or popping of jaw	□ Yes □ No	Mouth breathing	□ Yes □ No	Sores or growth in mouth	□ Yes □ No
Dry mouth	□ Yes □ No	Mouth pain when brushing	□ Yes □ No		
Fingernail biting	□ Yes □ No	Orthodontic treatment	□ Yes □ No		

MEDICAL HISTORY

Physician's Name _____ Phone# _____ Date of last visit _____

Medications currently taking: _____

Pharmacy Name _____ Phone# _____

Place a check on either "yes" or "No" for each of the following:

Abnormal Bleeding W/ extractions or surgery	□ Yes □ No	Hear murmur	□ Yes □ No	Stroke	□ Yes □ No
		Heart problems	□ Yes □ No	Swelling of feet or ankles	□ Yes □ No
Aids	□ Yes □ No	Hepatitis, type____	□ Yes □ No	Swollen neck glands	□ Yes □ No
Anemia	□ Yes □ No	Herpes	□ Yes □ No	Thyroid problems	□ Yes □ No
Arthritis, Rheumatism	□ Yes □ No	High blood pressure	□ Yes □ No	Tonsillitis	□ Yes □ No
Artificial heart valve	□ Yes □ No	HIV positive	□ Yes □ No	Tuberculosis	□ Yes □ No
Artificial joints	□ Yes □ No	Jaundice	□ Yes □ No	Tumor or growth on head/neck	□ Yes □ No
Asthma	□ Yes □ No	Jaw pain	□ Yes □ No	Ulcer	□ Yes □ No
Back Problems	□ Yes □ No	Kidney disease	□ Yes □ No	Venereal Disease	□ Yes □ No
Blood disease	□ Yes □ No	Liver disease	□ Yes □ No	Weight loss, unexplained	□ Yes □ No
Cancer	□ Yes □ No	Low blood pressure	□ Yes □ No	Do you wear contact lenses?	□ Yes □ No
Chemical dependency	□ Yes □ No	Mitral valve problems	□ Yes □ No		
Chemotherapy	□ Yes □ No	Nervous problems	□ Yes □ No		
Circulatory problems	□ Yes □ No	Pacemaker	□ Yes □ No	WOMEN:	
Congenital heart Lesions	□ Yes □ No	Psychiatric care	□ Yes □ No	Are you pregnant?	□ Yes □ No
Cortisone treatments	□ Yes □ No	Radiation treatment	□ Yes □ No	due date: _____	
Cough persistent or bloody	□ Yes □ No	Respiratory disease	□ Yes □ No	Are you nursing?	□ Yes □ No
Diabetes	□ Yes □ No	Rheumatic Fever	□ Yes □ No		
Emphysema	□ Yes □ No	Scarlet fever	□ Yes □ No	ALLERGIES:	□ Codeine
Epilepsy	□ Yes □ No	Shortness of breath	□ Yes □ No	□ Aspirin	□ Sulfa
Fainting / dizziness	□ Yes □ No	Sinus trouble	□ Yes □ No	□ Local Anesthetic	□ Iodine
Glaucoma	□ Yes □ No	Skin rash	□ Yes □ No	□ Barbiturates	□ Latex _____
Headaches	□ Yes □ No	Special diet	□ Yes □ No	□ Penicillin	□ Other _____

To the best of my Knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and / or medication. I further certify that I consent to the performing of x-rays and oral examinations.

_____ _____

Signature of Patient / Parent if minor Date Signature of Doctor Date

UPDATES (To complete at a later date)

Has there been any change in your health within the last year? □ Yes □ No, If so, for what condition? _____

Are you taking any new medications? □ Yes □ No, If so, what? _____

_____ _____

Signature of Patient / Parent if minor Date Signature of Doctor Date

.....

Has there been any change in your health within the last year? □ Yes □ No, If so, for what condition? _____

Are you taking any new medications? □ Yes □ No, If so, what? _____

_____ _____

Signature of Patient / Parent if minor Date Signature of Doctor Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

I Have received from this office a copy of the Notice of Privacy Practices.

Signature of Patient / Parent / Responsible Party _____ Date _____