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 YOU

Date: ________/________/________

Patients Name: ____

What you prefer to be called? ________________________________

☐ Male ☐ Female Birth date: _______/_______/_______ Age: _______

Address: ____

____
CITY STATE ZIP

Home Phone#: (___________)__________________________

Work Phone#: (___________)__________________________

Cell Phone#: (___________)__________________________

Email Address: ____

Employer: ____

Employer's Address: ______________________________________

____
CITY STATE ZIP

Occupation: ____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name: ____

Do you have children? ☐ Yes ☐ No How Many? _________

Who may we thank for referring you? __________________________

ACCOUNT INFO

Person responsible for account

Name: ____

Relation: ____

Billing Address: _______________________________________

____
CITY STATE ZIP

SS#: ____

Drivers License#: _____________________________________

I hereby authorize assignment of my insurance rights and benefits directly to Dr. Samy Ibrahim for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

____
Initials

EMERGENCY CONTACTS

Whom should we contact? __________________________________

Relation: ____

Contact Phone#: (_________)________________________

Medical Doctor? ______________________________________

Doctor's Phone#: (_________)________________________

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 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, until my treatment plan is completed.

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

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