BARDMOOR FAMILY DENTAL

PATIENT INFORMATION:

Patient Name _____ Social _____

Address _____ City/State/Zip _____

Phone Number _____ Cell _____ E-mail Address _____

Sex: M F Birthday _____ Circle one: Married Widowed Single

Employer/School _____ Occupation: _____

Who can we thank for referring you? _____

In Case of Emergency: Name: _____ Phone _____ Relationship _____

Reason for today's visit _____ Former Dentist _____ City/State_____

Date of last dental visit _____ Date of last dental x-rays_____

DENTAL INSURANCE:

Insurance company: _____ Who is responsible for this account? _____

Member ID _____ Group # _____ Is the patient covered by additional insurance? Y N

Subscriber's Name _____ Birthday_____ Social _____

Relationship to patient _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above company and assign directly to Dr. J. Abdelghani all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If my account goes to collections, I agree to pay all legal and collection fees. I authorize the use of my signature on all insurance submissions. Dr. J. Abdelghani may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____ _____

Signature of Patient, Parent, Guardian or Legal Representative

Please print name of Patient, Parent, Guardian or Legal Representative

_____ _____

Date

Relationship to Patient

MEDICAL HISTORY

PLACE A MARK ON "YES" OR "NO" TO INDICATE YOU HAVE/DO ANY OF THE FOLLOWING:							
Bad breath	Y N	Pain around ear	Y N	Sensitivity when biting	Y N	Smoke Cigarettes	Y N
Grinding teeth	Y N	Periodontal disease	Y N	Sores or growth in mouth	Y N	Use Marijuana	Y N
Gums swollen or tender	Y N	Sensitivity to cold	Y N	Loose teeth or broken	Y N	Food Collection	Y N
Jaw pain or tiredness	Y N	Sensitivity to heat	Y N	Blisters on lips or mouth	Y N		
Lip or cheek biting	Y N	Mouth breathing	Y N	Do you chew on one side	Y N		
Bleeding gums	Y N	Fingernail biting	Y N	Sensitivity to sweets	Y N		
PLACE A MARK ON "YES" OR "NO" TO INDICATE YOU HAVE ANY OF THE FOLLOWING:							
Use of biphosphonate med	Y N	Blood disease	Y N	Herpes	Y N	Rheumatic Fever	Y N
Fen-phen	Y N	Circulatory problems	Y N	High blood pressure	Y N	Scarlet fever	Y N
AIDS/HIV	Y N	Congestive Heart	Y N	Low blood pressure	Y N	Sinus problems	Y N
Anemia	Y N	Diabetes	Y N	Mitral valve prolapse	Y N	Stroke	Y N
Arthritis	Y N	Epilepsy	Y N	Nervous problems	Y N	Thyroid problems	Y N
Artificial heart valves	Y N	Fainting and dizziness	Y N	Osteoporosis	Y N	Tuberculosis	Y N
Artificial joints	Y N	Headaches	Y N	Take/Taken Biophosphonates	Y N	Tumor or growth	Y N
Respiratory disease/asthma	Y N	Heart problems	Y N	Psychiatric care	Y N	Ulcer	Y N
Back Problems	Y N	Heart Murmur	Y N	Shortness of breath	Y N	Weight loss	Y N
Abnormal Bleeding	Y N	Hepititis	Y N	Pacemaker	Y N	Women: Pregnant	Y N
Cancer	Y N	Jaundice or liver	Y N	Radiation treatment	Y N	Nursing	Y N
Kidney Disease	Y N						

Allergies _____

Medications _____