Smiles by Design Dental

Zana Alnaqib, DDS

Patient Name: ____ Date: __________
Last, First MI (Preferred Name)
Gender: M F Family Status: __________________
Social Security #: __________________________ Birth Date: ________________________
Phone (Home): ____________ (Work): ____________ (Cell): ___________Email ____________
Address:______________________City:___________________State:_______Zip:_________

Whom should we contact in case of emergency? ______________________Phone Number__________

Have you ever had any of the following? Please check those that apply:
Physician's Name ________________Office Phone______________Date of Last Exam______________

Yes No
- ❑ ❑ 1. Are you under Medical Treatment Now?
- ❑ ❑ 2. Have you ever been hospitalized for any surgical operations or serious illness?
- ❑ ❑ 3. Are you taking any medications including non-prescription medications? If yes, What are you taking? ____________
  ____
  ____
  ____
- ❑ ❑ 4. Have you ever had to be premedicated prior to dental work? If yes, explain
  ____
- ❑ ❑ 5 Do you use tobacco?
- ❑ ❑ 6. Do you have a history of alcohol or substance abuse?
- ❑ ❑ 7. Are you allergic to or have you had reactions To the following:
- ❑ ❑.....Local anesthetic (such as Novacaine)
- ❑ ❑.....Penicillin or other antibiotic ____________
- ❑ ❑.....Sulfa drugs
- ❑ ❑….Latex
- ❑ ❑.....Iodine
- ❑ ❑.....Aspirin
- ❑ ❑.....Other __________________

8. Women Only
- ❑ ❑ Are you pregnant or think you may be?
- ❑ ❑ Are you nursing?
- ❑ ❑ Are you taking birth control?

Yes No
- ❑ ❑High Blood Pressure
- ❑ ❑ Heart Disease, please explain
  ____
- ❑ ❑ Rheumatic Fever
- ❑ ❑ Swollen Ankles
- ❑ ❑ Fainting/Seizures
- ❑ ❑ Asthma
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Epilepsy/Convulsions
- ❑ ❑Leukemia
- ❑ ❑ Diabetes
- ❑ ❑ Kidney Disease
- ❑ ❑ Aids or HIV Infection
- ❑ ❑ Thyroid problems
- ❑ ❑ Cardiac Pacemaker
- ❑ ❑ Heart Murmur
- ❑ ❑ Angina
- ❑ ❑ Frequently tired
- ❑ ❑ Respiratory Problem
- ❑ ❑ Emphysema
- ❑ ❑ Cancer
- ❑ ❑ Radiation Therapy
- ❑ ❑ Joint Replacement or implant
- ❑ ❑ Hepatitis/Jaundice
- ❑ ❑ Sexually transmitted disease
- ❑ ❑ Stomach troubles / Ulcers
- ❑ ❑ Hay fever/ Allergies
- ❑ ❑ Recent weight loss

Yes No
- ❑ ❑ Stroke
- ❑ ❑ Chest pain
- ❑ ❑ Tuberculosis
- ❑ ❑ Glaucoma
- ❑ ❑ Liver Disease
- ❑ ❑ Anemia

Dental History

How many time do you brush your teeth daily?_______

Do you use a manual or electric toothbrush?_________

When was your last dental cleaning?______________

Do your gums bleed? ___________________
Have you had previous gum surgery?___________
Do you have a history of periodontal (gum) disease?________
Do you grind your teeth? __________________
Do you uses a night guard?_________________

What is the reason for your visit today?____

• **Whom may we thank for referring you to our office?** ________________________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________________ Birth date: ____________________

Phone (Home): ____________ (Work): ____________ Ext: _____ Best time to call: __________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________________ Occupation: ____________________

Address: ______________________________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ______________________________

____

Patient is responsible for submitting secondary insurance claims.

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that submission of all procedures to dental insurance is done as a courtesy to the patient. Patients also understand insurance companies may not cover all incurred charges and therefore he or she will be personally responsible for any unpaid balances. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. Patients will be responsible for their estimated portion at time of service. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In the event this account falls delinquent over 90 days, we reserve the right to collect money through a collection agency or attorney. All fees incurred will be the responsibility of the patient.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______________________________ Date: __________ Relationship to Patient: __________
Signature of patient, parent or guardian

______________________________ Date: __________ Relationship to Patient: __________
Signature of guarantor of payment/responsible party