

PATIENT INFORMATION

Responsible Party (if not patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
Responsible Party is also a Policy Holder for Patient    Primary Insurance Policy Holder    Secondary Insurance Policy Holder

**Patient Information:**

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Sex:        Male                Female        Marital Status:    Married        Single        Divorced        Separated        Widowed  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
E-mail: \_\_\_\_\_ I would like to receive correspondences via email

Employment	Full Time	Part Time	Retired	Additional Comments: _____ _____ _____
Status: Student	Full Time	Part Time		
Employer: _____	Occupation: _____			
Pharmacy: _____	Phone: _____			
Emergency Contact: _____	Phone: _____			

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:    Self    Spouse    Child    Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ .00    Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:    Self    Spouse    Child    Other  
Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ .00    Rem. Deduct: \_\_\_\_\_ .00

## MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever taken Fosamax, Boniva or Actonel?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use controlled substances?  Yes  No If yes, please explain: \_\_\_\_\_

Women: Are you Pregnant or trying to be?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia Hepatitis <input type="radio"/> Yes <input type="radio"/> No  | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | A Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No    | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst Fainting <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No          | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Tumors or Growths Ulcers <input type="radio"/> Yes <input type="radio"/> No   |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker Heart <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No           | <input type="radio"/> Yes <input type="radio"/> No                       | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I affirm the information given is true to the best of my knowledge. I certify I have dental insurance as listed above and assign benefits directly to Samer K. Riad, DDS, its owner and associates. Samer K. Riad, DDS may use my health care information and disclose information for purposes of obtaining payment and determining benefits. I authorize use of my signature on all insurance claims.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_