Welcome

Ed Samra, D.D.S.

Patient Information (Confidential)

Name:_____ ( ) Male ( ) Female
Birthdate: ____/____/____ Age: _____ Soc. Sec.# ____/____/_____
Address: _____City: _____ State: ____ Zip: _____
Phone: _____ Work Ph:_____ Cell #_____
Would you like to be contacted via e-mail for your appointments or treatment? ( ) Yes ( ) No
If Yes: Please provide your e-mail address:_____
Check appropriate box: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed
Employer: _____ Phone: _____
Are you currently a F/T student? ( ) Yes ( ) No Name of School: _____
How were you referred to our office: _____
In case of an emergency contact: _____Phone: _____ Relationship: _____

Responsible Party

If same as above check here: ( ) Self/Same as above
Name: _____ Birthdate:____/____/____ Soc. Sec. ____/____/_____
Address: _____ City: _____ State: ___ Zip: _____
Employer: _____ Work Phone: _____
Relationship to patient: _____

Insurance Information

If same as above check here: ( ) Self/Same as above
Insured Name _____Birthdate: ____/____/_____ Soc. Sec._____/____/_____
Employer: _____ Phone: _____
Insurance Company: _____ Group # _____ Id# _____
Insurance Company Phone #: _____ Relationship to patient: _____

If You Have Any Additional Dental Insurance Coverage Please Notify The Front Office.

I certify by signing below that all information is complete and correct.

Signature: _____ ***Date:*** ___/___/___

Please continue to the next page

PATIENT HISTORY

Patient Name:_____ **Date:**____/_____/20___

Dental History

Are you experiencing a specific dental problem? If yes, describe:_____ Yes / No
If yes, how long have you experienced this problem:_____
Are you having pain at this time?_____ Yes / No
Have you ever been advised that you have gum disease? Dentist Name:_____ Yes / No
How often do you brush your teeth?_____
How often do you floss your teeth?_____
Do your gums bleed? If yes, when?_____ Yes / No
Does food catch between your teeth? If yes, where?_____ Yes / No
Do you have any loose teeth? If yes, where?_____ Yes / No
Do you ever have clicking, popping or discomfort in the jaw joint?_____ Yes / No
Do you grind your teeth?_____ Yes / No
Do you like your smile? Yes/No Would you like to know about cosmetic options?_____ Yes / No
What is the name and city of your last dentist?_____
What is the reason you left your last dentist?_____
Were you satisfied with the care they provided for you?_____ Yes / No
When was your last dental visit?_____
How often do you see a dentist for professional dental services?_____

Medical History

Are you currently under the care of a physician? If yes, why?_____ Yes / No
What is the name and city of your physician?_____
Have you ever been hospitalized? If yes, why?_____ Yes / No
Have you ever had an injury to your head, neck, or jaw? If yes, when?_____ Yes / No
Do you currently smoke? If yes, how many cigarettes/packs per day?_____ Yes / No
Are you taking any medications, pills, or other drugs? If yes, what?_____ Yes / No
Have you been asked to pre-medicate for dental services? If yes, why?_____ Yes / No
Do you have? prosthetic hip__, joint prosthesis__, bone plates__, screws__, other_____ Yes / No
Are you allergic to any medications or substances? If yes what?_____ Yes / No
( ) Penicillin ( ) Aspirin ( ) Codeine ( ) Latex ( ) Metals ( ) Acrylic ( ) Other:_____
Women Only: Are you pregnant, trying to get pregnant, or breast feeding? _____ Yes / No

Do you now or have you ever had any of the following? Please circle Yes / No for each item

Heart Trouble/ Disease:	Y/ N	Bruise Easily:	Y / N	Kidney Problems:	Y / N	Blood Disease:	Y / N
Heart Murmur :	Y / N	Excessive Bleeding:	Y / N	Hepatitis A:	Y / N	High Blood Pressure:	Y / N
Irregular Heart Beat:	Y / N	Cancer:	Y / N	Hepatitis B:	Y / N	Low Blood Pressure:	Y / N
Angina/Chest Pain:	Y / N	Metal Plates:	Y / N	Hepatitis C:	Y / N	Thyroid Disease:	Y / N
Cong. Heart Disorder:	Y / N	Chemotherapy:	Y / N	Epilepsy/Seizures:	Y / N	Phen-Phen:	Y / N
Mitral Valve Prolapse:	Y / N	Diabetes:	Y / N	AIDS:	Y / N	Oral Herpes:	Y / N
Artificial Heart Valve:	Y / N	Heart Pace Maker:	Y / N	HIV Positive:	Y / N	Drug Addiction:	Y / N
Heart Surgery:	Y / N	Heart Attack:	Y / N	Psychiatric Care:	Y / N	Other: Please explain below	

Have you ever had any other serious illness not checked above? Describe:_____

To the best of my knowledge, I certify under penalty of perjury, that the above information is true and correct. If I have any changes in my health or if my medications change, I understand that it is my responsibility to inform the dentist and staff immediately.

_____ Date:____/_____/20___
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed by Doctor:_____ Date:____/_____/20___

Updates:

Date	Patient Signature	Changes	Dr.'s Signature
Date	Patient Signature	Changes	Dr.'s Signature

ED SAMRA, D.D.S

INFORMED CONSENT

☐ Initial:_____ I understand that the dental office(s) of Ed Samra, D.D.S. will take the necessary dental radiographs(x-rays) needed to evaluate my oral health and will provide a routine dental prophylaxis in the absence of gum disease.

☐ Initial:_____ I understand that the dental office(s) of Ed Samra, D.D.S. will submit a claim to my dental insurance carrier as a courtesy and in good faith, however in the event that my insurance carrier does not remit payment to the dental office(s) Ed Samra, D.D.S. within 60 days, all charges incurred by myself and my dependants will be transferred to my account for immediate payment.

☐ Initial:_____ I understand that delinquent balances over 30 days will incur a late charge of $30.00 per month and that if any outside collections efforts are required including any necessary attorney/court fees they will be added to my account and ultimately my responsibility.

☐ Initial:_____ I understand that any co-payments or deductibles are my responsibility to know ahead of time and that any amount quoted in office by the staff of the dental office(s) of Ed Samra, D.D.S are estimates according to my dental insurance coverage and that any remaining amount must be paid in full within 30 days.

☐ Initial: _____ **I understand that any appointments cancelled without 24 hours notice will be billed to my account a $50.00 charge for each hour missed.**

☐ Initial: _____ I understand that any returned checks are subject to a $35.00 fee.

AUTHORIZATION FOR SIGNATURE ON FILE *(insurance patients only)*

Release of Information/Financial Responsibility/Payment

I,_____ and/or_____ hereby
Name of Insured (Primary Subscriber) Name of Patient

authorize the dental office(s) of Ed Samra, D.D.S to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependants through my employment with _____.
Name of Employer

I authorize payment of my dental benefits otherwise payable to me, now be paid directly to the dental office(s) of Ed Samra, D.D.S. I will review the treatment plan and fees and will agree to be responsible for all charges and balances not paid by my insurance company, unless the treating dentist is contracted with my dental plan prohibiting all or a portion of such charges. To the extent under applicable law, I authorize the release of any information relating to the claim. This authorization will be valid from this date and will expire upon termination of my relationship with the dental office(s) of Ed Samra, D.D.S.

I _____, am financially responsible for all charges incurred by
Name of Responsible Person

myself and any of my dependants. I understand and agree to each of the above listed policies of the dental office(s) of Ed Samra, D.D.S and by signing below agree to honor each policy.

Sign:_____ **Date:**_____