Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____ Birth Date _____ Gender _____ Marital Status _____

Employer _____ Occupation _____

Whom may we thank for referring you to our practice? _____

Contact Information

Patient's Home Phone (_____) _____-_____ Business Phone (_____) _____-_____ ext _____

Cell Phone (____) _____-_____ E-mail Address _____

Where and when is the best place and time to contact you? _____

In an emergency who shall we contact? _____ Relationship _____ Phone (____) _____-_____

Dental Health and Concerns

Date of last dental exam _____ Date of x-rays _____ Date of last cleaning _____

What are your chief concerns and/or reasons for this visit? _____

How do you feel about the appearance of your teeth, your gums and your smile? _____

Do you have any specific concerns about your dental health and treatment that you would like us to know about?

_____

Please answer Y or N and give details (severity, location…) to any Yes answers in the space that follows below the questions:

Do you routinely take antibiotics (pre-medication) before a dental visit?	Yes	No
Do you experience headaches, migraines, earaches or neck pains?	Yes	No
Do you use tobacco products? Type and amount?_____	Yes	No
Do you consume alcohol? Amount per week _____	Yes	No
Are your teeth sensitive to (please check): ___hot ___cold ___sweets ___pressure?	Yes	No
Do your gums bleed when brushing or flossing?	Yes	No
Have you had any periodontal (gum) problems?	Yes	No
Have you had orthodontic (braces) treatment?	Yes	No
Do you wear removable dental appliances, a night guard or a retainer?	Yes	No
Do you chew on one side or avoid any areas of your mouth? Are you having pain?	Yes	No
Do you experience dry mouth?	Yes	No

Please give details to any Yes answers above: _____

_____

How often do you floss?_____ Brush? _____ Type of Brush _____

Medications

Please list all prescription/non-prescription medication(s) that you are taking and dosages if known. _____

_____

_____

_____

_____

Have you taken Fosamax, Actonel or other drugs to treat or prevent osteoporosis? Yes No

Have you taken Pondimin, Redux or Phen-fen? Yes No

Allergies

Aspirin	Yes	No	Unknown
Local anesthetics	Yes	No	Unknown
Penicillin/antibiotics	Yes	No	Unknown
Sulfa drugs	Yes	No	Unknown
Narcotics/codeine	Yes	No	Unknown
Latex	Yes	No	Unknown

Other allergies_____

If you have any allergies, please describe._____

_____

Medical Health and History Please explain any "Yes" answers to the questions below.

Abnormal bleeding	Yes	No	Unknown	Irregular heartbeat/arrhythmia	Yes	No	Unknown
AIDS or HIV	Yes	No	Unknown	Kidney disease	Yes	No	Unknown
Anorexia/bulimia	Yes	No	Unknown	Liver disease/jaundice	Yes	No	Unknown
Arthritis	Yes	No	Unknown	Mental health disorders	Yes	No	Unknown
Asthma	Yes	No	Unknown	Mitral valve prolapse	Yes	No	Unknown
Blood pressure - High or Low	Yes	No	Unknown	Neurological disorders	Yes	No	Unknown
Blood transfusion	Yes	No	Unknown	Orthopedic replacement-hip/knee/joint/etc.			
Cancer/chemotherapy	Yes	No	Unknown		Yes	No	Unknown
Chemical dependency	Yes	No	Unknown	Osteoporosis	Yes	No	Unknown
Chest pain with exertion	Yes	No	Unknown	Pacemaker/cardiac surgery	Yes	No	Unknown
Chronic pain	Yes	No	Unknown	Persistent swollen glands	Yes	No	Unknown
Congenital heart defect	Yes	No	Unknown	Pregnant	Yes	No	Unknown
Cough producing blood	Yes	No	Unknown	Nursing	Yes	No	Unknown
Cough lasting longer than 3wk	Yes	No	Unknown	Radiation treatment	Yes	No	Unknown
Diabetes	Yes	No	Unknown	Severe/rapid weight loss	Yes	No	Unknown
Type I or II				Sinus trouble	Yes	No	Unknown
Epilepsy and/or seizures	Yes	No	Unknown	Sleep disorder	Yes	No	Unknown
G.E. reflux	Yes	No	Unknown	Stroke	Yes	No	Unknown
Glaucoma	Yes	No	Unknown	Lupus	Yes	No	Unknown
Heart/cardiac disease	Yes	No	Unknown	Thyroid/endocrine disorder	Yes	No	Unknown
Hemophilia	Yes	No	Unknown	Tuberculosis (TB)	Yes	No	Unknown
Hepatitis Type A, B or C	Yes	No	Unknown	Ulcers or other GI disease	Yes	No	Unknown
Immunosuppression	Yes	No	Unknown	Other not listed_____			

Please explain and describe any yes answers to the above questions. _____

_____

_____

Please list all current or recent medical conditions and/or surgeries and/or current medical treatments. _____

_____

_____

Other Information

Who is your physician? _____ Phone (_____) _____-_____

When was your last physical exam?_____ Findings _____

Are there any concerns you would like the practice staff to know about (insurance, family, accommodations, etc.)?_____

_____

Disclosure

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ **Date** _____

Office Use Only

Dentist/hygienist's notes and comments (note and date)_____

_____

_____

_____

_____

32 PEARLS - GENTLE DENTISTRY
JAMEEL A. AFTAB, DMD

DENTAL INSURANCE

So that we can expedite your insurance reimbursement please fill out the information below.

Patient Name: _____ DOB:____/____/____
Last Name, First Name

Relationship to Insured: __Self __Spouse __Child __ Other

Insured/
Subscriber Name: _____ DOB:____/____/____
Last Name, First Name

Insured
Mailing Address: _____ City/State/Zip:_____

Insured Social Security#(Required): ____-___-____

Insured Identification #:_____

Company Name:_____ Insurance Plan Name:_____

Insurance Plan Group # or Policy # :_____

Note for those patients who have dental insurance:

It is our pleasure to assist you in maximizing your insurance benefits by submitting your dental claims for you. If your carrier utilizes today's technologies, then your claims will be submitted electronically via our computer system daily. This expedites your reimbursement.

Your range of benefits depends solely on what your employer decided to purchase. Some plans cover as little as 30% or as much as 100% of dental services
(less applicable deductibles, and plan maximums).

Some plans base the amount of benefit on a schedule of fees arbitrarily developed by insurance companies. For this reason, you may receive a lower percentage than the reimbursement level indicated in your dental plan.

Your insurance company is responsible to you, and not to our office. However, we will assist you in any way we can to maximize your available benefits.

WWW.DrAftab.com

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HEALTH INSURANCE AND PORTABILITY ACT OF 1996

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Revised 07/30/04

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

- **Purpose of Consent**: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
- **Notice of Privacy Practices**: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
- **Right to Revoke**: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed below. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may *refuse* to treat you or to continue treating you if you revoke this Consent. Please ask for the signature form to revoke your consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

32 PEARLS - GENTLE DENTISTRY
JAMEEL A. AFTAB, DMD
604 S. MAIN STREET
DAVISON, MI. 48423
810-653-1500
WWW.DrAftab.com

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

*Name:*_____

Signature: _____ *Date:* _____