REGISTRATION AND HISTORY

1 Patient Information

Date____
SS/Patient ID #__________________________________
Patient Name___________________________________
Last Name
____
First Name Middle Initial
Address____
City____
State____________________ Zip____________________
E-mail____
Sex ___M ___F Age___________
Birthday____
___Married ___Widowed ___Single ___Minor
___Separated ___ Divorced ___Partnered for __yrs
Occupation ______________________________________
Patient Employer/School___________________________
Employer/School Address__________________________
____
Employer/School Phone (___)_______________________
Spouse's Name___________________________________
Birthdate____
SS#____
Spouse's Employer________________________________
Whom may we thank for referring you?______________

2 Dental Insurance

Who is responsible for this account?___________________________
Relationship to Patient?_____________________________________
Insurance Co.____
Group #____
Is patient covered by additional insurance? ___Y ___N
Subscriber's Name____
Birthdate_______________ SS#/Pt. ID______________________
Relationship to patient______________________________________
Insurance Co.____
Group #____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_______________________ and assign directly to **Dr. Christine Saad** 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. I authorize the use of my signature on all insurance submissions.

Name of Insurance Company(ies)

The above-named dentist 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. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

______________________ ____________________________
Date Relationship to Patient

3 Phone Numbers

Home (___)____________________ Work (___)__________________ Ext.____ Cell(___)_________________________
Spouse's Work (___)_________________________ Best time and place to reach you_____________________________
IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)
Name____ Relationship_____________________________
Home Phone (___)____ Work Phone(___)__________________________

4 Dental History

Reason for today's visit_____________
____
Former Dentist_____________________
City/State_________________________
Date of last dental visit_____________
Date of last dental x-rays___________

Place a mark on "yes" or no" to indicate
If you have had any of the following:

Bad Breath ___Y ___N
Bleeding Gums ___Y ___N
Blisters on Lips or Mouth ___Y ___N
Burning Sensation on tongue___Y ___N

Chew on one side of mouth ___Y ___N
Cigarette, pipe, or cigar ___Y ___N
Clicking/Popping Jaw ___Y ___N
Dry Mouth ___Y ___N
Fingernail biting ___Y ___N
Food Collection between teeth ___Y ___N
Foreign objects ___Y ___N
Grinding teeth ___Y ___N
Gums swollen or tender ___Y ___N
Jaw Pain or tiredness ___Y ___N
Lip or Cheek biting ___Y ___N
Loose teeth or broken fillings ___Y ___N

Mouth Breathing ___Y ___N
Mouth pain __ _Y___N
Orthodontics ___Y ___N
Pain around the ear ___Y ___N
Periodontal treatment ___Y ___N
Sensitivity to cold ___Y ___N
Sensitivity to head ___Y ___N
Sensitivity to sweets ___Y ___N
Sensitivity when biting ___Y ___N
Sores or growths in mouth___Y ___N
How often do you floss?___________
How often do you brush?__________

5 Health History

Physician's Name____ Date of last visit___________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ioimin, Adipex, Fastin (phentermine) , Pondimin (fenfluramine) and Redux (dexfenfluramine). ___Y ___N

Place a mark on "yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	___Y ___N	Epilepsy	___Y ___N	Respiratory Disease	___Y ___N
Anemia	___Y ___N	Fainting or dizziness	___Y ___N	Rheumatic Fever	___Y ___N
Arthritis, Rheumatism	___Y ___N	Glaucoma	___Y ___N	Scarlet Fever	___Y ___N
Artificial Heart Valves	___Y ___N	Headaches	___Y ___N	Shortness of Breath	___Y ___N
Artificial Joints	___Y ___N	Heart Murmur	___Y ___N	Sinus Trouble	___Y ___N
Asthma	___Y ___N	Heart Problems	___Y ___N	Skin Rash	___Y ___N
Back Problems	___Y ___N	Hepatitis Type___	___Y ___N	Special Diet	___Y ___N
Bleeding abnormally, with		Herpes	___Y ___N	Stroke	___Y ___N
Extractions or surgery	___Y ___N	High Blood Pressure	___Y ___N	Swollen Feet or Ankles	___Y ___N
Blood Disease	___Y ___N	Jaundice	___Y ___N	Swollen Neck Glands	___Y ___N
Cancer	___Y ___N	Jaw Pain	___Y ___N	Thyroid Problems	___Y ___N
Chemical Dependency	___Y ___N	Kidney Disease	___Y ___N	Tonsilitis	___Y ___N
Chemotherapy	___Y ___N	Liver Disease	___Y ___N	Tuberculosis	___Y ___N
Circulatory Problems	___Y ___N	Low Blood Pressure	___Y ___N	Tumor or growth on head	
Congenital Heart Lesions	___Y ___N	Mitral Valve Prolapse	___Y ___N	or neck	___Y ___N
Cortisone Treatments	___Y ___N	Nervous Problems	___Y ___N	Ulcer	___Y ___N
Cough, persistent/bloody	___Y ___N	Pacemaker	___Y ___N	Venereal Disease	___Y ___N
Diabetes	___Y ___N	Psychiatric Care	___Y ___N	Wear contact lenses	___Y ___N
Emphysema	___Y ___N	Radiation Treatment			

Women: Are you pregnant? ___Y ___N Due Date________________________ Are you nursing? ___Y ___N

Taking birth control pills? ___Y ___N

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:______________________________________

____

____

____

Pharmacy Name____

Phone(____)____

ALLERGIES

___ Aspirin

___Barbiturates (Sleeping Pills)

___Codeine

___Iodine

___Latex

___ Local Anesthetic

___Penicillin

___Sulfa

___Other_______________

____

6 Updates (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ___Y ___N

For what conditions?____

Are you taking new medications?__________ If so, what?____

Patient's Signature____ Date______________________________

Doctor's Signature____ Date______________________________

Christine M. Saad DDS PC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-248-693-5844.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم –(248-693-5844) رقم هـ الصم والبكم:.