Patient information

We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office?

Date

Patient's name

Address

City, state, ZIP

Home phone

Work phone

Cell phone

Email

Birth date

Social Security number

Employer

Occupation

Emergency contact name

Emergency contact phone

How would you like to be contacted? ☐ Home phone ☐ Work phone ☐ Cell: text ☐ Cell: voice message ☐ Email

Sex ☐ F ☐ M

Dental insurance

Primary insurance

Subscriber's name

Subscriber's Social Security number

Subscriber's date of birth

Relationship to patient

Insurance company

Insurance phone

Subscriber's employer

Do you have dual coverage? If yes, please complete the following: ☐ Yes ☐ No

Secondary insurance

Subscriber's name

Subscriber's Social Security number

Subscriber's date of birth

Relationship to patient

Insurance company

Insurance phone

Subscriber's employer

Dental history

What is the reason for your visit today?

Last dental cleaning

Last X-rays

Do your gums bleed? ☐ Yes ☐ No

Are your teeth sensitive to heat or cold? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

Why?:

Do you feel nervous about having dental treatment? ☐ Yes ☐ No

Why?:

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe:

Medical history

1. Are you having pain or discomfort at this time? ☐ Yes ☐ No

2. Have you been a patient in the hospital during the last two years? ☐ Yes ☐ No

3. Are you now taking any medications or drugs? ☐ Yes ☐ No

4. Have you taken any medications or drugs during the last two years, including appetite suppressants (fen-phen: fenfluramine and phentermine, or dexfenfluramine) or any medications to prevent osteoporosis (for example Boniva, Fosamax, Actonel)? ☐ Yes ☐ No

5. Have you been under the care of a medical doctor during the last two years? ☐ Yes ☐ No

Physician's name, phone and address:

6. Are you sensitive or allergic to any medications or anesthetics? ☐ Yes ☐ No

If yes, please list:

Medical history, continued

7. Indicate which of the following you have had or have at present. Circle Y or N for each item:

Heart problems	Y / N	Artificial heart valve	Y / N
Rheumatism	Y / N	Hepatitis A or B (infectious)	Y / N
Heart disease or attack	Y / N	Sinus trouble	Y / N
Arthritis	Y / N	Allergy to latex or metal	Y / N
Angina pectoris	Y / N	Hay fever	Y / N
Yellow jaundice	Y / N	Kidney trouble	Y / N
Congenital heart disease	Y / N	Artificial joints (hip, knee)	Y / N
Liver disease	Y / N	AIDS	Y / N
Heart surgery	Y / N	High blood pressure	Y / N
Allergies or hives	Y / N	HIV positive	Y / N
Mitral valve prolapse	Y / N	Blood transfusion	Y / N
Rheumatic fever	Y / N	Arteriosclerosis	Y / N
Glaucoma	Y / N	Tuberculosis	Y / N
Cortisone medicine	Y / N	Emphysema	Y / N
Cancer	Y / N	Bruise easily	Y / N
Radiation therapy	Y / N	Hemophilia	Y / N
Fainting or dizzy spells	Y / N	Venereal disease	Y / N
Stroke	Y / N	Anemia	Y / N
Thyroid problems	Y / N	Cold sores / fever blisters	Y / N
Chemotherapy	Y / N	Sickle cell disease	Y / N
Nervousness	Y / N	Chronic cough	Y / N
Drug addiction	Y / N	Epilepsy or seizures	Y / N
Diabetes	Y / N	Ulcers or tumors	Y / N
Asthma	Y / N		

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or tiredness? ☐ Yes ☐ No

9. Do your ankles swell during the day? ☐ Yes ☐ No

10. Do you use more than two pillows to sleep? ☐ Yes ☐ No

11. Have you lost or gained more than ten pounds in the past year? ☐ Yes ☐ No

12. Do you ever wake up from sleep and feel short of breath? ☐ Yes ☐ No

13. Are you on a special diet? ☐ Yes ☐ No

14. Do you have or have you had any disease, condition or problem not listed? ☐ Yes ☐ No

For women: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

If pregnant, which month? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's signature	Printed name	Date

Patient consent form

Patient's name

_____

In reading and signing this form, it is understood that English is the language that I understand and use to communicate.

Initials _____

1. Drugs, medications and anesthesia

I understand that antibiotics, analgesics and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, vomiting, dizziness, miscarriage and cardiac arrest. I understand that medications, drugs and anesthetics may cause drowsiness and lack of coordination, which can be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, nor operate any vehicle or hazardous device while taking medications and/or drugs, or until fully recovered from their effects (this includes a period of at least twenty-four (24) hours after my release from surgery). I understand that occasionally, upon injection of a local anesthetic, I may have prolonged persistent anesthesia, numbness and/or irritation to the area of injection. I understand that if I select to utilize nitrous oxide, Atarax, chloral hydrate, Xanax or any other sedative, possible risks include, but are not limited to, loss of consciousness, obstruction of airway, anaphylactic shock and cardiac arrest. I understand that someone needs to drive me home from the dental office after I have received sedation. I also understand that someone needs to watch me closely for a period of 8 to 10 hours following my dental appointment, to observe for possible deleterious side effects, such as obstruction of airway.

Initials _____

2. Hygiene and periodontics (tissue and bone loss)

I understand that the long-term success of treatment and status of my oral condition depends on my efforts at proper oral hygiene (i.e. brushing and flossing) and maintaining regular recall visits. Periodontics: I understand that I have a serious condition, causing gum and bone inflammation and/or loss, and that it can lead to loss of my teeth and other complications. The various treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I also understand that although these treatments have a high degree of success, they cannot be guaranteed. Occasionally, treated teeth may require extraction.

Initials _____

3. Removal of teeth

I understand that the purpose of the procedure/surgery is to treat and possibly correct my diseased oral tissue. The doctor has advised me that if this condition persists without treatment or surgery, my present oral condition will probably worsen over time. Potential risks include, but are not limited to, the following: A. Post-operative discomfort, swelling, prolonged bleeding, tooth sensitivity to hot or cold, gum shrinkage (possibly exposing crown margin), tooth looseness, delayed healing (dry socket) and/or infection (requiring prescriptions or additional treatment, i.e. surgery). B. Injury to adjacent teeth, caps or fillings (requiring the recommendation of crowns, replacement of fillings, fabrication of crowns, or extraction), or injury to other tissues not within the described surgical area. C. Limitation of opening; stiffness of facial and/or neck muscles; change in bite, or temporomandibular joint (jaw joint) difficulty (possibly requiring physical therapy or surgery). D. Residual root fragments or bone spicules left when complete removal would require extensive surgery or needless surgical complications. E. Possible bone fracture which may require wiring or surgical treatment. F. Opening of the sinus (a normal cavity situated above the upper teeth) requiring additional surgery. G. Injury to the nerve underlying the teeth resulting in itching, numbness or burning of the lip, chin, gums, cheek, teeth and/or tongue on the operated side; this may persist for several weeks, months or, in remote instances, permanently.

Initials _____

I give my consent for the doctor to perform the treatment/procedure/surgery for teeth # _____, or other procedures deemed necessary or advisable to complete the planned operation. If any unforeseen condition should arise in the course of the operation, calling for the doctor's judgment or for procedures in addition to or different from those now contemplated, I request and authorize the doctor to do whatever he or she may deem advisable, including referral to another dentist or specialist. I also understand that the cost of this referral would be my responsibility.

Initials _____

4. Fillings

I have been advised of the need for fillings, either silver or composite (plastic), to replace tooth structure lost to decay. I understand that with time fillings will need to be replaced due to wearing of material. In cases where very little tooth structure remains, or existing tooth structure fractures off, I may need to receive more extensive treatment (such as root canal therapy, post and build-up, and crowns), which would necessitate a separate charge. I understand that the silver amalgam restoration is an acceptable procedure according to the American Dental Association guidelines. The advantages and disadvantages of alternative materials have been explained to me.

Initials _____

5. Endodontic treatment (root canal therapy)

The purpose and method of root canal therapy have been explained to me, as well as reasonable alternative treatments, and the consequences of non-treatment. I understand that following root canal therapy my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the tooth. I understand that treatment risks can include, but are not limited to, the following: A. Post-treatment discomfort lasting a few hours to several days, for which medication will be prescribed if deemed necessary by the doctor. B. Post-treatment swelling of the gum area in the vicinity of the treated tooth, or facial swelling, either of which may persist for several days or longer. C. Infection. D. Restricted jaw opening. E. Breakage of root canal instruments during treatment, which may, in the judgment of the doctor, be left in the treated root canal or bone as part of the filling material, or may require surgery for removal. F. Perforation of the root canal with instruments, which may require additional surgical treatment or result in premature tooth loss or extraction. G. Risk of temporary or permanent numbness in the treatment area. If an "open and medicate" or pulpotomy procedure is performed, I understand that this is not permanent treatment, and I need to pay for and finish final root canal therapy. If root canal treatment is not finalized, I expose myself to infection and/or tooth loss. If failure of root canal therapy occurs, the treatment may have to be redone, root-end surgery may be required, or the tooth may have to be extracted.

Initials _____

6. Crowns and bridges (caps)

I understand that sometimes it is not possible to match the color of the natural teeth exactly with artificial teeth. I understand that at times, during the preparation of a tooth for a crown, pulp exposure may occur, necessitating possible root canal therapy. I understand that, like natural teeth, crowns and bridges need to be kept clean, with proper oral hygiene and periodic cleaning; otherwise decay may develop underneath and/or around the margins of the restoration, leading to future dental treatment.

Initials _____

7. Dentures, complete or partial

The problems of wearing dentures have been explained to me, including looseness, soreness, possible breakage, and relining due to tissue change. Follow-up appointments are an integral part of the maintenance and success of a prosthetic appliance. The doctor should immediately examine persistent sore spots. I further understand that surgical intervention (i.e. tori [bone] removal, bone recontouring, or implants) may be needed for dentures to be properly fitted. I also understand that due to bone or other complicating factors, I may never be able to wear dentures to my satisfaction.

Initials _____

8. Pedodontics (child dentistry)

I understand that the following procedures are used to treat pediatric patients and are accepted in the dental profession. A. Positive reinforcement: rewarding the child who shows desirable behavior with compliments, praise, a pat or hug, and/or token objects or toys. B. Voice control: the attention of a disruptive child is gained by changing the tone or increasing the volume of the doctor's voice. C. Hand-over-mouth exercise: the disruptive child is told that a hand is to be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child that if the disruptive noise stops, the hand will be removed. When the noise stops, the hand is removed and the child is praised for cooperating. If the noise resumes, the hand is again placed on the mouth and the exercise repeated. At no time is the airway ever restricted. D. Physical restraint: restraining the child's disruptive movements by holding down their hands, upper body, head and/or legs by use of the dentist's or assistant's hand or arm, or by use of a special device (referred to as a "papoose board"). E. Nitrous oxide and/or oral sedation: nitrous oxide is a mild gas that is mixed with oxygen and used to sedate a person. It is administered through a mask placed over the child's nose. Oral sedation is medication given to children to help them relax. With their use, the parent or guardian must understand that the child should not eat or drink for a period of four hours prior to the sedation appointment. The parent or guardian must be available to escort the child home after the sedation procedure, and observe their behavior throughout the day. I understand that with the use of an injection used to numb the tooth for dental procedures, the possibility exists that the child may inadvertently bite their lip, causing injury. I understand the need to return to the office for evaluation if swelling and/or pain in my child does not go away after a sufficient period of time. I understand the need to return to the office within three months following nerve treatment of a "baby tooth" for evaluation, and the possibility of it then needing an extraction.

Initials _____

I understand that no guarantee or assurance has been given that the proposed treatment will be curative and/or successful to my complete satisfaction. I agree to cooperate completely with the recommendations of the doctor while I am under his or her care, realizing that any lack of the same could result in less than optimum results. I certify that I have had an opportunity to read and fully understand the terms and words within the above, and consent to the operation and explanation referred to or made. I have been encouraged to ask questions, and have had them answered to my satisfaction.

Patient or legal representative's signature	Relationship	Date
Doctor	Witness	

Patient financial responsibility

I agree to be financially responsible for any dental services rendered which are not benefits of my insurance plan or for which my insurance policy does not reimburse Dr. Ahdout. This shall include, but not be limited to, lapses in coverage, cancellation of policy, changes in benefits and misinterpretation of benefits. If such situations occur, Dr. Ahdout's normal and customary fees shall apply. All appointments which are missed or not cancelled 24 hours in advance will incur a $75.00 per half-hour charge. No further appointments will be made until this charge is paid.

Patient's or guardian's name	Patient's or guardian's signature	Date

Ensuring that our patients receive high quality care is the goal of our practice.

Payments are due at the time of treatment. We accept cash and major credit cards. We also offer payment plans through CareCredit, Cherry and Sunbit, which allow you to start treatment today and spread payments over time.

Please indicate the form of payment you choose to settle your account:

- [ ] Cash
- [ ] Visa, MasterCard, Amex, Discover
- [ ] Healthcare financing: CareCredit, Cherry or Sunbit (subject to credit approval)

Patient's signature		Date

Acknowledgement of receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement.

I, _____, have received a copy of this office's Notice of Privacy Practices and Dental Materials Fact Sheet, as required by law.

Patient's name	Patient's signature	Date
_____	_____	_____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- [ ] Individual refused to sign
- [ ] Communication barriers prohibited obtaining the acknowledgement
- [ ] An emergency situation prevented us from obtaining acknowledgement
- [ ] Other (please specify): _____