

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: ___/___/___

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 | Stroke 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 |

