# *Welcome!* *Ed Samra, D.D.S.*

## *Patient Information (Confidential)*

Name:__________________________________________________ ( ) Male ( ) Female
Birthdate: _____/_____/____ Age: ________ Soc. Sec.# ______/____/_______
Address: ___________________________________City: ______________ State: ____ Zip: ______
Phone: _____________________ Work Ph:____________________ Cell #____________________
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: _______

May we contact you via e-mail for appointment reminders, outstanding treatment, and billing? Y / N
If Yes: Please provide your e-mail address:_______________________________________________

## *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:_____/_____/20_____**

*We Now Offer Appointments 7AM – 7 PM and on Saturdays!*

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
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

### 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 take antibiotics before dental services? If yes, why?_________________ Yes / No
Do you do recreational drugs, Vape or smoke E-Cigarettes? If Yes, what? ___________________ Yes / No
Do you have; prosthetic hip__, joint prosthesis__, bone plates__, screws___, other_____________ Yes / No
Are you allergic to any medications or substances? 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 or 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 | Osteoporosis: | 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 |
|---|---|---|---|
| _______ | _____________________ | __________ | ______________________ |
| _______ | _____________________ | __________ | ______________________ |

# INFORMED CONSENT

 Initial:_______ I understand that the dental office 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 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 of 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 $30.00 per month late fee 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 are deductibles are my responsibility to know ahead of time and that any amount quoted in office by the staff of the dental office 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 are subject to a cancellation fee.**
 Initial: _______ I understand that any returned checks are subject to a $35.00 fee.

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## 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 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 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 of Ed Samra, D.D.S.

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**This section must be signed by financially responsible party**

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 of Ed Samra, D.D.S. and by signing below agree to honor each policy.

**Sign:_______________________________________________Date:____/______/20___**