

*Maisa M Idriss D.M.D
The Smile Designer*

Patient Information

Patient Name: _____ Date: _____

Last First Middle

Married: _____ Single: _____ Child: _____ Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (Home): _____ (Cellular): _____ Work: _____

Do you prefer to receive calls at home: _____ Work: _____ cellular: _____

Social Security #: _____ Date of Birth: _____

Drivers License#: _____ State: _____

E-Mail address: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____ Phone # _____

Health History

Please check those that apply:

Allergies:

If yes what to :

Arthritis

Aids / HIV infection

Artificial Joints

Asthma

Blood Disease

Cancer

Diabetes

Coumiden

Epilepsy/ seizures

Excessive Bleeding

Fainting / dizziness

Glaucoma

Martial Valve

Prolapse

Hepatitis / Jaundice

Head Injuries

Heart Disease

Heart Murmur

Heart Attack

High Blood Pressure

Kidney Disease

Liver Disease

Mental Disorders

Nervous Disorders

Pacemaker

Pregnancy

Due date: _____

Radiation Treatment

Respiratory

Problems

Rheumatic Fever

Rheumatism

Sinus Problems

Stomach Problems

STROKE

Tuberculosis

Tumors

Ulcers

OTHER:

- Are you currently taking any medications, if yes please list them:

- Have you ever had any complications following dental treatment? Yes No

If yes please explain _____

- Are you now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• **Women only:** Are you pregnant? Yes No
Are you nursing? Yes No
Are you taking oral contraceptives? Yes No

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative

Dental Office Yellow Pages Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ Work: _____ Cellular: _____

Address: _____

State _____ City _____ Zip _____

Authorization and release

Payment is due in full at time of treatment unless prior arrangements have been made.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

Patients who have dental insurance, please understand this office will help prepare insurance forms or assist in making collections from insurance companies. We will credit any such collections to your account. However, this dental office cannot render services on the assumption that our charges will be paid solely by an insurance company.

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

X _____ Date: _____

Signature of patient (or parent/ guardian if minor)