FAMILY DENTAL GROUP
DR. SHARIF DDS

PATIENT INFORMATION

Welcome to our Practice!

Patient's Full Name _____ Date _____
SSN _____ D.O.B. _____ Sex: _____Male _____ Female
Home Phone_____ Cell Phone_____EMAIL: _____
Mailing Address_____
Physical Address_____
Employer_____ Employer Phone_____
Employer Address _____
Full Time Student?_____ Where? _____

Lives with:
' Self
' Spouse
' Parent
' Other

Marital Status:
' Single ' Divorced
' Married ' Widowed

Spouse's Name_____

Were you referred? _____ Yes _____ No
If *YES*, by whom?
_____
If *NO*, how did you hear about us?
_____

Primary Insured:
' None
' Self
' Spouse
' Child
' Other

My insurance plan is:
(Please select only one of the following)
' Provided through an employer
' An individual policy
' Provided by the Department of Medical Assistance Services

Primary Insured Full Name_____ Phone_____
SSN_____ DOB_____ Relationship to Patient_____
Address_____

Please provide the following employment information for the Primary Insurance Subscriber.
Employer_____ Employer Phone_____
Employer Address_____
Primary Dental Insurance Company_____
Group Number_____ Subscriber Number_____

NOTE: Please understand that the above information must be completed in order to file your insurance claims. If this information is not complete and correct, then your insurance claims may not be processed.

Responsible Party:
' Self
' Other

If "other", please complete the following section.

Name_____ SSN _____
Home Phone_____ Work Phone_____ Mobile Phone_____
Address_____
Employer_____ Employer Phone_____
Employer Address _____

Accounts over 30 days will receive a monthly charge of 1.5% (annual 18%) on any unpaid balance. Accounts are to be paid in full the day services are rendered. Financial responsibility will be with the individual responsible for the account regardless of insurance coverage. Your insurance coverage is an agreement between you, your employer, and the insurance carrier, not the office of Dr. Sharif.D.D.S.

I hereby authorize payment to Dr. Sharif.D.D.S. of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

I acknowledge all above information to be true and correct.

A BROKEN APPOINTMENT IS A LOSS TO EVERYONE. PLEASE INFORM US AT LEAST 48 HRS IN ADVANCE IN YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. PATIENT WILL BE CHARGED THAT DAY'S SERVICE OR AN HOURLY RATE, WHICHEVER IS LESS FOR BROKEN APPOINTMENT.

_____ _____
Patient/Responsible Party Signature Date

PLEASE CHECK IF YOU HAVE BEEN DIAGNOSTED WITH OR HAD A HISTORY OF ANY OF THE FOLLOWING:

Allergic to:
- ' Aspirin
- ' Codeine
- ' E-Mycin
- ' Anesthetics
- ' Latex Gloves
- ' Penicillin
- ' Sulfur

History of:
- ' Anemia
- ' Angina
- ' Anti-Depressants
- ' Artificial Joints (Knee/Hip)
- ' Blood Thinner Medication
- ' Diabetes
- ' Glaucoma
- ' Hepatitis
- ' High/Low Blood Pressure

History of:
- ' History of Cancer
- ' History of Stroke
- ' HIV
- ' Prolong Bleeding Problem
- ' Seizures
- ' Steroid Treatment
- ' Tuberculosis/Liver/Kidney
- ' Meds for osteoporosis or other bone problems

History of:
- ' Severe Cardiac Problems
- ' Heart Attacks
- ' Artificial Heart Valve
- ' Pacemaker Placement
- ' Vascular Valves/Splint(s)
- ' Infective Endocarditics
- ' Heart Repair Surgery
- ' Congenital Heart Defects

Other Allergies/Medical Conditions _____

DEPENDENCIES:

Are you addicted to nicotine (smoker)?	Yes	No
Do you use prescription sleep aids (nightly)?	Yes	No
Do you use alcohol (daily)?	Yes	No
Have you been taking pain medication daily for over 6 months?	Yes	No

LIST ALL MEDICATION/REASONS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PRESENTLY BEING TREATED BY:

PHYSICIAN:
Dr._____Phone:____-_____
Address_____
_____

SPECIALIST:
Dr._____Phone:_____-_____
Address_____
_____

Pharmacy:_____
Address_____
Phone: _____-_____

Have you been a patient in the hospital in the past 2 years?	Yes	No
When you walk up the stairs or take a walk, do you ever have to stop because of pain in the chest or shortness of breath, or because you are very tired?	Yes	No
Have you ever tested positive for the HTLV III Antibody? (AIDS VIRUS)	Yes	No
Do you ankles swell during the day?	Yes	No
Have you lost or gained more than 10 pounds in the past year?	Yes	No
Are you on a special diet?	Yes	No
Has your medical doctor ever said you have a cancer or tumor?	Yes	No
Are you pregnant? If yes, what month? _____	Yes	No
Are you taking birth control pills?	Yes	No

Check any of the following which apply as motivators for your seeking dental treatment:

- ' Esthetics
- ' Prevention
- ' Guilt
- ' Peer Pressure
- ' Health
- ' Function
- ' Status
- ' Pain

Check any of the following which express your concerns in receiving dental treatment:

- ' Fear
- ' Pain
- ' Money
- ' Time

CONSENT: The undersigned hereby gives authorization for X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs, I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with patient and further authorize and consent for Doctor to choose and employ such assistance as he deems fit. I understand that anesthetic agents normally used in most dental procedures embody a certain risk. I acknowledge all above medical history to be true and correct.

_____ _____
Patient/Responsible Party Signature Date

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