Margolian Dentistry

Patient Contact Information

Mr Mrs Ms Miss Dr

First Name: _____ Last Name: _____ Date of Birth: _____/_____/_____
DD MM YY

Address: _____ Apt/Unit # _____ City: _____ Postal Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Preferred Contact Method: _____

Emergency Contact Person: _____ Phone Number: _____

Insurance Information

Primary Insurance Company

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
DD MM YY

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Employer: _____ Name of Insurance Company: _____

Secondary Insurance Company (if applicable)

Name of Policy Holder: _____ Date of Birth: _____/_____/_____
DD MM YY

Group Policy/Plan Number: _____ I.D./Certificate Number: _____

Employer: _____ Name of Insurance Company: _____

I, understand, certify that I (or my dependent) have insurance coverage and assign directly to Drs. Bishara-Margolian DPC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Drs. Bishara –Margolian to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Authorized Signature: _____

* All fees or balances not covered by your dental insurance policy will be payable at time of visit. You must provide us with all insurance information. We do not have access to your private insurance policy information unless provided to us.

Referral Information

How did you hear about us?

Website Internet Yellow Pages Referral

Family Member or Friend: _____

Other: _____

Dental History

Please check any of the following that may apply to you:

Sensitivity
Tooth Pain or Discomfort While Chewing
Headaches, earaches, or neck pain
Jaw Joint Pain (clicking/cracking)
Broken Teeth or Fillings
Grinding or clenching teeth
Bleeding, swollen or irritated gums
Loose or shifting teeth
Bad breath or taste in the mouth

When was your last dental visit? _____ What was done at that visit? _____
When having dental treatment do you require sedation? nitrous oxide (laughing gas) oral medication
Do you smoke or chew tobacco? _____ If "yes" for how long? _____

If you could change your smile, you would…

Make your teeth brighter/whiter
Make your teeth straighter
Close spaces
Replace fillings
Repair chipped teeth
Replace missing teeth
Replace crowns
Have a smile makeover
Other: _____

What is the most important thing to you about your visit today? _____

Medical History

Please check any of the following that apply to you:

AIDS	Diabetes	High Blood Pressure	Rheumatic Fever
Allergies	Emphysema	HIV Positive	Seizures
Anaemia	Excessive Bleeding	Jaundice	Snoring/Sleep Apnoea
Arthritis	Fainting	Kidney Disease	Stomach Problems
Artifical Joints	Glaucoma	Liver Disease	Stroke
Asthma	Heart Conditions	Low Blood Pressure	Thyroid Disease
Blood Disorders	Heart Murmur	Pacemaker	Tuberculosis
Cancer	Heart Disease	Pregnant	Ulcers
Chemotherapy	Hepatitis A, B or C	Respiratory Problems	Other _____

Do you have any allergies?

Aspirin Codeine Penicillin Sulpha Drugs Local Aesthetic Latex Other _____

Do you have any joint replacements? _____Do you require pre-medication for dental work? _____

Are you currently under a physician's care? _____ For? _____

Physician's Name and Phone Number: _____

Pharmacy's Name and Phone Number: _____

I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of my knowledge and have not knowingly omitted any information. If required, I consent to my physician being contacted regarding any specific medical questions. I authorize Drs. Bishara-Margolian and their staff to perform necessary diagnostic procedures and treatment as required to achieve a proper level of dental care.

Signature: _____ Date: _____

Signature of Dentist: _____