A-Plus Dental Care

Farah Saeb, DDS

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (**Last, First, MI**)			Date of Birth ___/___/___	AGE	Social Security No.	Today's Date ___/___/___
Address (**Street**)	(**city**)	(**Zip code**)	Email Address: _____		Home Phone (_____) _____-_____	
Employer Name			Occupation		Work Phone (_____) _____-_____	
Employer Address	City		Zip Code		Cell phone (_____) _____-_____	
Spouse's OR Parent's Name (**Last, First, MI**)	DOB ___/___/___		Social Security No.		Spouse's OR Parent's Work Phone (_____) _____-_____	
Emergency Contact	Relationship				Phone (_____) _____-_____	

INSURANCE INFORMATION

Primary Insurance Name	Address (Street – City – State – Zip)		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. No./ Social security #	Group No.
Secondary Insurance Name	Address (Street – City – State – Zip)		Phone (_____) _____-_____
Name of Insured	Relationship	I.D. No./ Social Security #	Group No.

CONSENT FOR TREATMENT

1. I hereby authorize Farah Saeb, DDS, or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor(s) to make a thorough diagnosis of (name of patient) _____'s dental needs. Upon such diagnosis, I authorize Farah Saeb, DDS, or designated associate Doctor or staff to perform all recommended treatments as necessary by or under the supervision of Dr. Farah Saeb or her associate Doctor. This may include but not limited to administration of local anesthetic, use of appropriate medicaments and materials as required to provide proper care. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
2. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. I grant my permission to Farah Saeb, DDS, or her assigns, to telephone me at home or at my work to discuss matters related to this form.
3. The goal of the office of Farah Saeb, DDS is constantly strive to provide you with the best dental care available today. We are proud of the quality of services that we provide and we are open to suggestions. However, in case of any grievance, the patient or patient's responsible party agrees to pay all costs and reasonable attorney fees if suit were instituted hereunder.

I have read and understood the above information. By my signature I consent to the treatment described in this paper.

Patient's/ Parent's Signature_____ Date _____

Patient Name	MEDICAL STICKER	**MEDICAL HISTORY**	
DATE		BP	Pulse

Physician's Name _____ **Phone** _____ Date of Last Exam _____

1. Indicate which of the following you have had, or have at present, Circle "yes" or "no" to each item.

Heart surgery	Yes	No	Diet (Special/Restricted)	Yes	No	Hepatitis A (Infectious) B (serum).	Yes	No
Chest Pain/Angina	Yes	No	Diabetes	Yes	No	Sexually Transmitted Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	H.I.V. / AIDS	Yes	No
Heart attack	Yes	No	Glaucoma	Yes	No	Yellow Jaundice / liver disease	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Heart Pacemaker	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia/	Yes	No
Heart murmur	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Mitral Valve Prolapse	Yes	No	Hay Fever	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	Cortisone Medicine	Yes	No	Leukemia	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Ulcer	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Anemia	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells.	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

2. Have you ever taken Phen Phen/ Redox ? Yes NO
3. Have you taken any bis-phosphonate medication or Fosamax in past 2 years? Yes No

Medications name	Condition you take Medication for	Medications name	Condition you take Medication for

4. Have you been under the care of a medical doctor during the past two years? ..... Yes No
   If yes, for what condition? _____
5. Have you been a patient in the hospital during the past five years? ..... Yes No
   If yes, for what condition? _____
6. A re you aware of having an **allergic (or adverse)** reaction to:

a. Local anesthetic(e.g. Novocaine)	Yes	No	e. Sedatives	Yes	No
b. Antibiotics (e.g. penicillin)	Yes	No	h. Aspirin	Yes	No
c. Sulfa Drugs	Yes	No	I. Latex Rubber	Yes	No
d. Barbiturates	Yes	No	j. Other(please list)	Yes	No

7. Do you have or have you had any disease, condition, or problem not listed: Yes No
   If yes, please list: _____

Women Only: Are you: Pregnant? Yes, ___ Months No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

MEDICAL HISTORY REVIEWED BY:

Dentist Signature _____ DATE: _____

Medical History Update

Change _____

_____ No Change ☐ Staff ID _____ Date _____

Change _____

_____ No Change ☐ Staff ID _____ Date _____

Patient's Name:	Date:

DENTAL HISTORY

What is the reason for your visit today? _____

Do you have any dental problems now? **Yes** **No** **If yes, please describe:** _____

Do you feel nervous about having dental treatment? Yes No If so, what is your biggest concern? _____

HAVE YOU EVER HAD:			**HAVE YOU EVER EXPERIENCED:**		
Orthodontic Treatment?(braces)	Yes	No	Bleeding or sore gums?	Yes	No
Gum treatment or gum surgery?	Yes	No	Clicking or popping of the jaw?	Yes	No
Any Trauma to the Mouth or Head?	Yes	No	Jaw joint pain?	Yes	No
If yes, explain_____			Any mouth lesions(Cold Sores or blisters) ?	Yes	No
TMJ treatment?	Yes	No	Difficulty in opening or closing your mouth?	Yes	No
DO YOU:			Difficulty in chewing on either side of the mouth?	Yes	No
Clench or grind your teeth while awake or asleep?	Yes	No	Headaches, neckaches or shoulder aches?	Yes	No
Hold foreign objects with your teeth (pencils, nails, etc.)?	Yes	No	Sore muscles (face, neck, shoulders)	Yes	No
Smoke or chew tobacco?	Yes	No	**Seizure during dental treatment**	Yes	No
How often do you brush your teeth?			How often do you floss or use other dental aids?		

Previous Dentist's Name_____ Telephone #_____

Date of Last Dental Visit_____ **Reason for your last dental visit?** _____

Date of Last Dental Cleaning_____

Date of Last Full Mouth X-rays_____

Is there anything else about your dental history that we should know so, we can provide a superior dental care for you? If yes, please describe

_____

DO YOU LIKE HOW YOUR TEETH LOOK? YES NO

DO YOU LIKE THE SHADE OF YOUR TEETH? YES NO

WOULD YOU LIKE TO ALIGN YOUR TEETH WITHOUT THE USE OF METAL BRACES? YES NO

(Please complete other side)