Family & Cosmetic Dentistry

Patient Information

First Name:_____ **M.I.:**_____ **Last Name**:_____

Salutation (circle one): Mr. Mrs. Miss Ms Dr. **Nickname**:_____

Address:_____ **City, State, Zip**:_____

Home Phone:_____ **Work phone**:_____ **Ext**:_____ **Cellular**: _____

Sex: O Male O Female **Marital Status**: O Married O Single O Divorced O Separated O Widowed

Birthdate:_____ **Soc. Sec**:_____

Email:_____ **May we send you reminders or information about new services? Yes No**

Employment Status: O Full Time O Part Time O Retired **Student Status**: O Full Time O Part Time

Name and number of Preferred Pharmacy:_____

Whom may we thank for referring you?_____

What is your time preference for appointments (circle one)? AM PM

Responsible Party/Policy Holder (*Responsible party is the individual responsible for the bill or Insured***)**

Name of the Insured/Responsible Party:_____

Relationship to Patient: O Self O Spouse O Child O Other

Soc. Sec (if different from above):_____ **Date of Birth (if different from above)**:_____

Employer:_____ **Insurance Company**:_____

Address:_____ **Address:** _____

City, State, Zip:_____ **City, State, Zip**:_____

Employer Phone #_____ **Insurance Phone #**_____

Do you have secondary insurance? YES NO **Insurance Group #**_____

Insurance ID#_____

In the event that insurance does not cover all charges, may we charge your credit card? YES NO

If YES, credit card information: O VISA O MC O AMEX #_____Exp: ___

CONSENT

1. The undersigned hereby authorizes doctor or staff to take 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.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services approved in this office for my dependents or myself is mine, due and payable at the time services are rendered unless other arrangements have been made.
4. I understand that if bill is past due, collection charges may be incurred to my account.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I understand that there will be a charge of $35 for failed appointments or cancellation without 24 hours notice if the office deems necessary.
7. I understand that claims are sent out as a service, but if insurance does not pay what was thought, it is the patient's responsibility.
8. I authorize this office to obtain any medical information about my dependents or me. I understand that this information will be kept in absolute confidence.
9. I hereby authorize payment of the dental benefits otherwise payable to me directly to Dr. Mirweiss Nawaz, DDS, PLLC
10. **I have been shown a copy of Notice of Privacy Practices and understand I can request a copy.**
11. **I give consent to use and disclose my protected health information to carry out treatment, payment activities and health care operations.**

Patient signature_____ **Date**_____ **Parent or responsible party**_____

Staff Member Signature_____ Date:_____

MEDICAL HISTORY

First Name:_____**M.I.:**_____ **Last Name**:_____

Are you under a physician's care now? O Yes O No O N/A _____

Have you ever been hospitalized or had a major operation? O Yes O No O N/A _____

Have you ever had a serious head or neck injury? O Yes O No O N/A _____

Are you taking any medications, pills, or drugs? O Yes O No O N/A _____

Do you smoke or use tobacco products? O Yes O No _____

Are you taking bisphosphonate drugs? Please check below O Yes O No θ Do you use controlled substances? O Yes O No

Fosamax θ Boniva θ Actonel θ Skelid θ Didronel θ IV Aredia θ IV Zometa

Women: Are you ☐ Pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other_____

Do you have, or have had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur*	☐ Lung Disease	☐ Stomach/Intestinal Disease
☐ Artificial Heart Valve*	☐ Drug Addiction	☐ Heart Pacemaker*	☐ Mitral Valve Prolapse*	☐ Stroke
☐ Artificial Joint*	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problems	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumor or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever*	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No O N/A _____

Comments: _____

_____

_____

* Condition may require medication N/A – Not answered by patient Reviewed by Staff Member:_____Date:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT or GUARDIAN DATE