

Welcome to Our Office

John Khouri DMD

Patient Information

#1 Name _____ Age _____ Home Phone (____) _____
First Mi Last

Address _____ Apt. No. _____ Work Phone (____) _____

City _____ State _____ Zip _____ Cell(____) _____

Birth Date _____ SS# _____ Full-time Student? ___Yes ___ No School Attending _____

In case of emergency contact _____ Relationship _____ Phone (____) _____

Are any of your family members patients of this office? ___Yes ___ No Name _____

Whom may we thank for referring you to our office? _____

Person responsible for the account:

#1 Name _____ Age _____ Sex _____ Home Phone (____) _____
First Mi Last

Birthdate _____ SS# _____ Work Phone (____) _____ Cell (____) _____

Address (if different) _____ Apt. No. _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ Relationship to Patient _____

Marital Status: ___Single ___Married ___Separated ___Divorced

#2 Name _____ Age _____ Sex _____ Home Phone (____) _____
First Mi Last

Birthdate _____ SS# _____ Work Phone (____) _____ Cell (____) _____

Address (if different) _____ Apt. No. _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ Relationship to Patient _____

Marital Status: ___Single ___Married ___Separated ___Divorced

Primary DENTAL insurance

Insured Name _____

Ins. Co. Name _____

Ins. Address _____

Ins. Phone (____) _____

ID# _____

Group Plan # _____

Effective Date _____

Secondary DENTAL insurance

Insured Name _____

Ins. Co. Name _____

Ins. Address _____

Ins. Phone (____) _____

ID# _____

Group Plan # _____

Effective Date _____

Patient Treatment Consent

I authorize the Dentist(s) or designated staff treating me to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. Upon such diagnosis I authorize the Dentist(s) to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me.

I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this practice to submit claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE.. I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested .

I agree to be responsible for payment of all services rendered on my behalf to my dependents. I agree that I am responsible for any unpaid claims. I have been made aware of all financial policies of the office.

Patient/Parent or Guardian Signature _____ Date _____

Medical History

Information that you feel insignificant could be directly related to your dental health. Answering the following questions will provide us with a thorough understanding of your physical condition for proper recommendations regarding your dental care. This information is strictly confidential. Thank you for completing all the questions in detail. Remember to include all information even if you do not think it to be important.

Patient's Name _____ Date _____

Do you have or have you ever been treated for:	Yes	No		Yes	No
Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hayfever	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur*	<input type="checkbox"/>	<input type="checkbox"/>	Allergies or Hives	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse*	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
History of Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Gastric-Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever*	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Lesions*	<input type="checkbox"/>	<input type="checkbox"/>	Adrenal/Pituitary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever*	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or Cobalt Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve*	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Cancer or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint*	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis/Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B (Serum)	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis-Other	<input type="checkbox"/>	<input type="checkbox"/>
Do You Smoke	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Bisphosphonate Regimen	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addition	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
			Psychiatric Treatment	<input type="checkbox"/>	<input type="checkbox"/>
			Phen/Fen Regimen*	<input type="checkbox"/>	<input type="checkbox"/>

***Do you need to take antibiotic premedication prior to dental treatment?**

Name of antibiotic normally prescribed _____
 Other _____

Allergic reaction to (hives or swelling):

Acrylic	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Local Anesthetic (Novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other (i.e., fruits)	_____	_____

If you are female are you:

Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Nursing	<input type="checkbox"/>	<input type="checkbox"/>
Taking Birth Control	<input type="checkbox"/>	<input type="checkbox"/>
Taking Hormone Medications	<input type="checkbox"/>	<input type="checkbox"/>

WARNING: Antibiotics reduce the effects of birth control pills

OB/GYN name, address, phone _____

Do you have any current health problems not listed above?

If yes, list _____

Are you currently being treated by a physician?

If yes list why _____

Date of last medical exam _____

Physician's name, address, and phone _____

Are you currently taking any medications, pills, or tonics? _____

List _____ For _____

List _____ For _____

List _____ For _____

Dental History

Reason for today's visit _____

Previous/Current Dentist _____ Address or phone # _____

Date of last dental visit _____ Date of last dental exam _____ Date of last complete x-rays _____
(18 films or Panorex)

Have you ever had any serious problems with past dental treatment? Yes No

If yes, explain _____

Do you have or have you ever been treated for:	Yes	No
Bad Breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums when Brushing/Flossing _____	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
Clicking or Popping Jaw _____	<input type="checkbox"/>	<input type="checkbox"/>
Grinding Teeth (Headaches) _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain, Soreness of Facial Muscles _____	<input type="checkbox"/>	<input type="checkbox"/>
Food Collecting Between Teeth _____	<input type="checkbox"/>	<input type="checkbox"/>
Loose Teeth or Broken Fillings _____	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Cold _____	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Hot _____	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Sweets _____	<input type="checkbox"/>	<input type="checkbox"/>
Sensitivity to Biting _____	<input type="checkbox"/>	<input type="checkbox"/>
Sores or Growths in Your Mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have dental implants? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you happy with your smile? _____	<input type="checkbox"/>	<input type="checkbox"/>

I have provided accurate information to the best of my knowledge related to my medical and dental health. I am responsible to inform the office of any changes in health history.

Patient Signature _____ Date _____
(If minor, parent or guardian)

Orthodontist _____ Date _____

Medical History Review and Update

Date _____ No Change Change

List Changes	New Medications
_____	_____
_____	_____
_____	_____

Patient's Signature _____ Dentist/Hygienist Signature _____

Medical History Review and Update

Date _____ No Change Change

List Changes	New Medications
_____	_____
_____	_____
_____	_____

Patient's Signature _____ Dentist/Hygienist Signature _____

Use reverse side for future visits for medical history updates.