NAME AGE PHONE

OCCUPATION

ORAL HYGIENE 1 2 3 4 | PEN HEP RF HEART SMOKE PG

DEPOSITS 1 2 3 4 | FU FL UP LP PERIO LA SM ORTHO

PERIODONT 1 2 3 4 | SHADE REFER: OS ORTHO PERIO ENDO

ORAL FINDINGS:

Comments:

DATE	Tooth	N_2O	Lid2%	SERVICE RENDERED	C	CHARGE

DATE	Tooth	N_2O	Lid2%	SERVICE RENDERED	C	CHARGE

NAME ______________________ PHONE ______________

PARENT OR GUARDIAN (if minor) ______________________

MARITAL STATUS S M D W PATIENT'S AGE ________ BIRTH DATE ______________

HOME ADDRESS ______________________ APT. # ________

CITY ______________ STATE ______________ ZIP ______________

PLACE OF EMPLOYMENT ______________ PHONE ______________
(Self or Parent)

HOW LONG EMPLOYED ______________________

SPOUSE'S NAME ______________________

SPOUSE'S EMPLOYMENT ______________ PHONE ______________

WHAT IS YOUR PRESENT DENTAL PROBLEM IF ANY? ______________________

____

DATE OF LAST DENTAL CHECK-UP ______________________

NAME OF FAMILY DOCTOR ______________________

(CIRCLE YES OR NO)

1. ARE YOU UNDER MEDICAL TREATMENT NOW? ______________ YES NO
____
2. ARE YOU TAKING ANY MEDICATIONS? ______________ YES NO
____
3. ARE YOU ALLERGIC TO PENICILLIN, NOVOCAINE, ETC.? ______________ YES NO
____
4. (WOMEN) ARE YOU PREGNANT? WHEN EXPECTING? ______________ YES NO
5. HAVE YOU EVER HAD TROUBLE WITH BLEEDING AFTER SURGERY? YES NO
6. DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING? (CIRCLE)

RHEUMATIC FEVER	ASTHMA	ARTHRITIS	SMOKING
HEART TROUBLE	TUBERCULOSIS	ANEMIA	TOBACCO CHEW
HIGH BLOOD PRESSURE	HEPATITIS YEAR ________	EPILEPSY	
DIABETES	ANY BLOOD DISEASE	ANY VENEREAL DISEASE	

7. IS THERE ANY OTHER INFORMATION THAT SHOULD BE KNOWN
ABOUT YOUR HEALTH? ______________ YES NO
ABOUT PREVIOUS DENTAL VISITS? ______________ YES NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____

PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT

______________________ RELATIONSHIP ______________

ADDRESS ______________________ PHONE ______________
work home

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU

______________________ RELATIONSHIP ______________

ADDRESS ______________________ PHONE ______________
work home

SELECT METHOD OF PAYMENT AND PLEASE UNDERSTAND OUR POLICY REGARDING YOUR SITUATION.

☐ CASH

PAYMENT IS DUE EACH DAY SERVICES ARE PROVIDED.

☐ INSURANCE

VERY FEW POLICIES ACTUALLY COVER 100% OF DENTAL WORK. YOUR PORTION OF THE BILL IS DUE THE DAY THE WORK IS DONE. AS A CONVENIENCE TO YOU WE WILL SUBMIT YOUR INSURANCE FORMS AT NO CHARGE. IF YOU HAVE ANY QUESTIONS REGARDING YOUR INSURANCE COVERAGE FEEL FREE TO ASK OUR RECEPTIONIST.

	PRIMARY	SECONDARY
NAME OF INSURED		
NAME OF INSURANCE COMPANY		
BADGE NO.		
SUBSCRIBER'S SOCIAL SECURITY NO.		

☐ MASTERCARD OR VISA

PLEASE SUBMIT CHARGE CARD TO RECEPTIONIST AFTER EACH APPOINTMENT.

☐ MEDICAL CARD (WELFARE)

PLEASE SHOW THE RECEPTIONIST YOUR MEDICAL CARD.

I UNDERSTAND DR. WAKIM'S FINANCIAL POLICY, AND THAT HE HAS THE RIGHT, IF HE CHOOSES, TO STOP TREATMENT IF MY PORTION OF THE BILL IS NOT PAID AS SPECIFIED ABOVE.

SIGNATURE ______________________ DATE ______________