FADY FAKHOURY, D.D.S.

Comprehensive Dentistry

Welcome! So we may provide you with the best possible care, please complete this medical form.
All information is confidential.

Date: _____/____/_____

Title: ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Dr. **Nickname:** _____

Name: First _____ **MI** _____ Last_____

Sex: ( ) M ( ) F **Marital Status:** _____ **DOB:** ____/____/_____

SS#: _____-_____-_____ **E-Mail** _____

Residence: _____

City _____ **State**_____ **Zip Code**_____

Phone: Home (____) _____-_____ **Work** (____)_____-_____

Cellular (____) _____-_____ **Other** (____)_____-_____

Employer: _____

For Insurance Purposes:

Do you have dental insurance? Yes No **Insurance Company:** _____

Group # _____ **Insured Person's Name:** _____

Insured Person's Employer:_____

SS# of Insured or Insurance ID #: _____ **Insured DOB:**____/____/____

Relationship to Insured Person:_____

Please provide a copy of your insurance card.

How were you referred to our office? Newspaper Ad ( ) Mailer ( ) Sign ( )
Friend or Relative ( ) Name:_____ Other ( ): _____

Are you interested in a whiter and brighter smile? Yes No

What prompted you to call our office for an appointment? _____

_____

Are you aware of an uncomfortable bite? Yes No

Has a dental office ever helped you set up a treatment plan? Yes No

Medical History:

Physician Name: _____ Phone #: (_____) _____-_____

Pharmacy Name: _____ Phone #: (_____) _____-_____

Are you taking any medications, vitamins, herbals or diet drugs? Please list: _____

_____

Are you allergic to any medications or latex? Please list: _____

_____

Have you ever had a reaction to a local anesthetic, general anesthetic or conscious sedation? Please explain: _____

Do you require pre-medication with antibiotics before dental appointments? _____

Do you have any Artificial Joints (Hip, Knee, Etc)? Please circle YES NO

Have you been hospitalized within the past five years? Please explain: _____

_____

WOMEN: Please Circle YES or NO

Are you pregnant? Month:_____ YES NO

Are you taking birth control? YES NO

Are you nursing? YES NO

Indicate which of the following you have had or have present. Please Circle YES or NO

Heart (Surgery, Disease, Attack)	Yes	No	Respiratory Problems	Yes	No
Chest Pain	Yes	No	Asthma	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No
Heart Murmur	Yes	No	Radiation or Chemotherapy	Yes	No
Mitral Valve Prolepses	Yes	No	AIDS or HIV	Yes	No
Rheumatic Fever	Yes	No	Liver Disease	Yes	No
Arthritis/ Rheumatism	Yes	No	Epilepsy or Seizures	Yes	No
Stroke	Yes	No	Sickle Cell Disease	Yes	No
Kidney Trouble	Yes	No	Drug or Alcohol Abuse	Yes	No
Ulcers/ GI Problems	Yes	No	Psychiatric Care	Yes	No
Diabetes	Yes	No	Cold Sores / Fever Blisters	Yes	No
Smoke or Chew Tobacco	Yes	No	Taking Blood Thinners or Aspirin	Yes	No

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 present me all the options so that I may make an informed decision as to my course of treatment. Once treatment is agreed upon, I authorize the Dentist(s) to perform needed dental treatment and administer or prescribe any necessary medications.

I assign all dental benefits to which I am entitled to the extent permitted under my dental insurance claim forms and receive payment directly from the Insurance Carrier with the notification "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 or requested.

_____ _____

Patient/ Parent or Guardian Signature Date