Patient Medical History

(Page 1)

Today's Date: _____

Patient Name: _____ DOB: _____

*****Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, medications that you may be taking, could have an important interrelationship with the dental treatment you will receive.*****

Please Circle Your Responses to the questions below.

Please describe your current health: Excellent Good Fair Poor

Have there been any changes in your general health in the past year? Yes No

If yes, please describe: _____

Are you now under a physician's care for a particular problem? Yes No
If yes, Doctor's Name & Reason ?

_____

Please list any past surgeries: _____

_____

Have you ever had a serious head or neck injury? Yes No
If yes, please explain: _____

Please list any medications you are currently taking: _____

_____

Women: Are you pregnant/trying to get pregnant? Yes No

Are you allergic to any of the following? Please circle ALL that apply or if none, circle no known allergies:

Aspirin Codeine Clindamycin Erythromycin Hydrocodone Keflex Penicillin Sulfa Drugs Tylenol

Acrylic Fluoride Local Anesthetics Latex Metals (nickel, gold, silver)

Other Allergies: _____

No Known Drug Allergies (Circle if No Allergies)

Have you ever had any complications following dental treatment? Yes No

If yes, Please explain: _____

Patient Medical History

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Today's Date: _____

Patient Name: _____ DOB: _____

Have you ever had joint or valve replacement? Yes No

If yes, please list Surgeons name, year of surgery, and premed you take: _____

_____

Are you taking a blood thinner, including Aspirin? Yes No

If yes, please list name of medication: _____

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

Aids/HIV Positive	Yes	No	Hemophilia	Yes	No
Alzheimer's Disease	Yes	No	Hepatitis A	Yes	No
Arthritis	Yes	No	Hepatitis B or C	Yes	No
Asthma	Yes	No	High Blood Pressure	Yes	No
Cancer	Yes	No	High Cholesterol	Yes	No
Chemotherapy	Yes	No	Jaw Popping/Clenching	Yes	No
Cold Sores/Fever Blister	Yes	No	Mitral Valve Prolapse	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Epilepsy or Seizures	Yes	No	Radiation Treatments	Yes	No
Excessive Bleeding	Yes	No	Rheumatic Fever	Yes	No
Excessive Thirst	Yes	No	Stroke	Yes	No
Fainting/Dizzy Spells	Yes	No	Thyroid Disease	Yes	No
Heart Attack/Failure	Yes	No	Tobacco User/Vape	Yes	No
Heart Murmur	Yes	No	Tuberculosis	Yes	No
Heart Disease/Trouble	Yes	No	Ulcers	Yes	No

Do you have or have you ever had a serious illness that is not listed above? Yes No

If yes, Please explain: _____

Comments: _____

_____

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

Signature of Patient, Parent or Guardian: _____

Date: _____

Patient Information **Today's Date:** _____

First_____MI___Last_____PreferredName_____

Address: Street_____City_____State____Zip Code_____

Phone: Home(___)_____Work(___)_____ext_____Mobile(___)_____

DOB: _____Social Security Number: _____ Email: _____

Patient Employer: _____ Sex: Male Female Marital Status: Married Single Divorced Widowed

In case of emergency, who should be notified? Name_____

Phone Number(___)_____Relation to patient_____

Responsible Party (Must Be Present to Sign as Responsible)

Name: First_____Last_____DOB: _____

Address: Street_____City_____State___Zip Code_____

Phone: Home(___)_____Work(___)_____ext_____Mobile(___)_____

Social:_____Employer: _____Relation to Patient: Mother Father Guardian

Dental Insurance Information

Primary Dental Plan Name:_____

Policy Number_____Group Number_____

Insured Name: First_____Last_____DOB:_____

Address: Street_____City_____State___Zip Code_____

Employer_____ Relation to Patient_____

Secondary Dental Plan Name:_____

Policy Number_____Group Number_____

Insured Name: First_____Last_____DOB:_____

Address: Street_____City_____State___Zip Code_____

Employer_____ Relation to Patient_____

Please Initial each line and sign below

Consent for Treatment and Payment Responsibility:

_____ I hereby authorize doctor and designated staff to take x-rays, study models, photographs and any diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my/my child's needs. Upon diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that I can ask for comeplete recital of any possible complications.

_____Our office files your insurance as a courtesy to you. Your insurance is a contract between you and your insurance company. YOU are ultimately responsible for all incurred fees. Claims are filed with the information you provide to our office and assignment of benefits is usually accepted, also as a courtesy. We will make every effort to file claims accurately, in a timely manner and to follow up on those claims.

Consent To Contact Consumer by Cell Phone/Email

_____ I agree, in order for Hassan Dentistry to service my account or to collect monies I may owe, Hassan Dentistry and/or their agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. They may also contact me by sending text messages or emails, using any email address I have provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing device. As applicable.

_____ I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court cost, if such be necessary.

Broken Appointment/Late Cancellation/Late Arrival Policy

_____ We are committed to providing you with quality care. It is our policy that should you fail or cancel **THREE** or more appointments without giving a 24 hour notice, you **could** be charged a $35 broken appointment fee. Should you arrive more than 10 minutes late for your appointment you will then be considered a **work in** (if our schedule allows time to work you in), if not we will reschedule your appointment. We do understand that emergencies do arise: however, these will be considered on a case by case basis. Should you incur a broken appointment charge, you will be required to pay the fee in full before we can schedule another appointment.

Appointment Confirmations

_____Due to an abundance of patients on a waiting list, we are now requiring that you confirm your appointment by noon the day before or we will cancel the appointment and schedule someone from the waiting list.

I have read and understand this disclosure. I agree that Hassan Dentistry, its employees and/or agents may contact me or charge me as described above.

Responsible Party Signature: _____Date: _____

Hassan Dentistry, P.C.
Mohammed H Hassan, DMD
200 Grove Park Lane, Suite 610
Dothan, AL 36305
Phone: (334) 699-7777 Fax: (334) 699-7778
Email: hassandentistry@gmail.com

Patient Name: _____ **DOB:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgment

I have been made aware of the offices Notice of Privacy Practices. (Copy is available upon request).

Signature: _____ **Date:** _____

Release of Medical Information

I authorize the release of information including diagnosis, records, examinations rendered to me/my child and claims information to anyone listed below. **SPOUSES ARE NOT AUTOMATICALLY INCLUDED**

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

This Release of Information will remain in effect until terminated by me in writing.

Signature: _____ **Date:** _____