Dental Pyramids PC *Imad Ayoubi DDS*

Medical-Dental History

Last Name______________________Middle __________First Name ______________________DOB____/___/____

Social Security____________________________ Marital Status: Single____Married____Widowed____Other____

Home Address____Apt_________________________ __

City____________________________State______Zip Code__________cell (_____) _________________________

email____Occupation_____________________ _______

Employer_______________________________Business Address____

Do you have dental Insurance Yes____ No______Relation to patient: Self Spouse Parent Other?

Insurance Company _______________________________________Group Number______________-_______

Insurance Address____

Social Security of policy holder or ID number____

Additional Insurance coverage yes_____**No** _____________Name of policy holder______________________

Social Security or Id Number____DOB_____/____/______________

Medical History

Do you have any of those?

Do you have a Chest pain, Yes NO, Do you have high blood pressure Yes NO

Do you have any heart surgery Yes NO, Do you have kidney problems Yes NO

Do you have diabetes Yes NO, Do you have or had kidney treatment Yes NO

Asthma Yes NO, Fainting Yes NO

Thyroid problem Yes NO, Epilepsy Yes NO

Bleeding Problems Yes NO, Arthritis/ Rheumatism Yes NO

Are you allergic to any medication, which?
____

Do you take any medication including birth control?
____
____
______

Have or had Bisphosphonates- Aredia/Fosamax : Yes NO
Do you have any artificial bone/joints, Yes NO
Have you been injected with any Botox or Cosmetic Fillers Yes NO
Have you had any breathing issues? Yes NO

Do you have HIV or any other viral disease?____

For Women:
Are you pregnant? Yes NO, How many Weeks_______, Are you Nursing Yes No

Please continue to next page

Dental History

Bleeding gums, or Halitosis Yes NO
Food collection between teeth Yes NO
Do you use electrical tooth brush? Yes NO, Do you floss? Yes No
Do you smoke? How many cigarettes a day _________________________________
Have you had Periodontal Therapy? Yes NO
Do you like your smile/teeth? Yes NO
Do you have sensitivity? Cold Hot Sweet

When was your last dental Examination? ____/ ____/ ______ or ___________ago

Have you ever had an unfavorable reaction to dental anesthetics? YES NO

Chief Dental Complaint:
____

Your Physician Name ___________________________________Telephone
____

Emergency Contact_____________________________________Telephone
____

Who we should thank for referring you to our office
____

AUTHORIZATION

I certify that, I and my dependent (s), have insurance coverage with ________________________and assign directly to Dental Pyramids PC (Dr. Imad Ayoubi) all insurance benefits, if any, otherwise payable to

me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist or dental practice may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits and coverage or the benefits payable for related services.

Payment is due in full at time of treatment unless prior arrangement have been approved

WE MAY APPLY INTEREST FOR ALL CLAIMS IN WHICH WE CAN NOT RESOLVE OR COLLECT AFTER 90 DAYS

CANCELLATION POLICY

IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HRS NOTICE.

Failure to do so may result canceling future appointments and applying broken appointment charges.

Signature________________________________**Date** ____/____/______