MOSTAFA BAKIR DMD
Personalized Family & Cosmetic Dentistry

Patient Information & Insurance Form

Date _____ Patient Name _____ Preferred Name _____
Physical Address _____ Home Phone _____
City _____ State _____ Zip Code _____ Cell Phone _____
Mailing Address _____ E-mail _____
City _____ State _____ Zip Code _____ SS#_____
Sex: Male ___ Female ___ Age _____ DOB _____ Single – Married – Widowed – Separated - Divorced
How do you wish for us to contact you? Home Phone ___ Cell Phone ___ Email ___
Occupation _____ Employer _____ Phone _____

Whom may we thank for referring you? _____

In case of an emergency, contact:

Name _____ Relationship _____ Phone _____

Who is financially responsible for this account? _____
Relationship to Patient _____ SS# _____
Insurance Company _____ Group # _____
Subscriber's Name _____ Subscriber's DOB _____
Subscriber SS# _____ Relationship to patient: _____
Is patient covered by secondary insurance? YES ___ NO ___
Insurance Company _____ Group # _____
Subscriber's Name _____ Subscriber's DOB _____

Assignment of benefits and release:
I hereby authorize the doctor to release all information necessary to secure the payment of benefit. I authorize the use of the signature on this form for all insurance submissions.

Patient Medical History

Physician _____ *Office Phone* _____

1. Are you under medical treatment or the care of a physician? ( )Y ( )N
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Y____ N ____
   If yes, please explain: _____
3. Are you taking any medication(s) including non-prescription/OTC medications or supplements? Y____ N ____
   If yes, please list: _____
4. Do you use tobacco, nicotine or any related alternative products (ex: vaping) of any kind? Y____ N ____
5. Do you use or have you ever used controlled substance(s)? Y___ N ___ *If yes, explain:* _____
6. Do you consume alcohol? Y____ N ____ If yes, how much and how often? _____
7. Are you allergic to or have you had any reactions to any of the following?

Local anesthetic ____	Barbiturates ____	Sedatives ____	Sulfa Drugs ____
Iodine ____	Aspirin ____	Any metals ____	Latex Rubber ____
Ibuprofen ____	Codeine ____	Penicillin/antibiotics _____	

Other (please list): _____

(continued on back)

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Do you or have you had any of the following (*please check all that apply):*

Heart Attack ____	High Blood Pressure ____	Asthma ____
Heart Disease ____	Low Blood Pressure ____	Respiratory Problems ____
Heart Murmur ____	Fainting / Seizures ____	Emphysema ____
Cardiac Pacemaker ____	Frequently Tired ____	Tuberculosis ____
Chest Pains ____	Anemia ____	Hepatitis A ____ B ____ C ____
Angina ____	Thyroid Problems ____	Liver Disease ____
Aids / HIV ____	Diabetes ____	Sexually Transmitted Disease(s) ____
Mitral Valve Prolapse ____	Stroke ____	Kidney Disease ____
Radiation Therapy ____	Epilepsy ____	Glaucoma ____
Cancer ____	Recent Weight Loss ____	Joint Replacement or Implant ____

Other: _____

If female:

Are you pregnant? Y____ N____ Are you breast feeding? Y____ N____

Patient Dental History

Name of previous dentist, location and contact information: _____

_____Date of last exam: _____

1. Do our gums bleed while brushing or flossing? ( )Y ( )N
2. Are your teeth sensitive to hot or cold? ( )Y ( )N
3. Are your teeth sensitive to sweet or sour? ( )Y ( )N
4. Do you feel pain in any of your teeth? ( )Y ( )N
5. Do you have any sores or lumps in or near your mouth? ( )Y ( )N
6. Have you had any head, neck or jaw injuries? ( )Y ( )N
7. Have you ever experienced any of the following problems in your jaw?
   Clicking/popping ( )Y ( )N Pain ( )Y ( )N Difficulty opening/closing ( )Y ( )N
8. Do you have frequent headaches? ( )Y ( )N
9. Do you clench or grind your teeth? ( )Y ( )N
10. Do you bite your lips or cheeks frequently? ( )Y ( )N
11. Have you had any orthodontic treatment? ( )Y ( )N
12. Do you wear dentures or partials? ( )Y ( )N
13. Have you ever received oral hygiene instructions regarding care of your teeth/ gums? ( )Y ( )N
14. Do you like your smile? ( )Y ( )N *If no, please explain:* _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist (or dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

X

Signature of patient/Parent/Guarantor/Responsible Party Date

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Appointment Agreement

The first step towards a beautiful, healthy smile is to schedule your routine dental appointment(s). Because w are a small family owned and operated dental care provider, we attempt to avoid over booking so that we may provide high-standard, quality care services in a timely manner. In order to continue providing this level of care to you, our patient, we request that you honor our Appointment Agreement. Thank you for choosing us as your dental care provider, as it is our privilege to serve you!

1. Please notify us, prior to seeing the dentist or hygienist of any changes to your insurance coverage, primary home address, phone numbers, medical situation or medications.
   Patient Initials _____
2. A 24-hour notice is required to cancel an appointment. If we are given less than a 24-hour notice, it is considered a broken appointment and is subject to a $50 fee that will be charged to your account. Excessive "no-shows", broken or canceled appointments will be required to make a deposit for future appointments.
   Patient Initials _____
3. Please provide a courtesy call if there is a possibility of tardiness; this also allows us to re-appoint if necessary.
   Patient Initials _____

I, _____, have read, understand and accept the terms of the Appointment Agreement.
(Print Responsible Party Name)

Patient: (print) _____

Responsible Party: (print) _____

Responsible Party: (signature)_____ Date: _____

We understand that you have a choice when selecting a dental healthcare provider for you and your family. It is an honor and privilege to serve you.

Thank you for choosing us!!