Dagher Family Dental
(513)385-5607

PATIENT INFORMATION

CONFIDENTIAL

(PLEASE PRINT)

DATE _____

NAME _____ **BIRTHDATE** _____ **SSN** _____

PREFERRED NAME _____ **HOME PHONE** _____ **CELL PHONE** _____

IS THERE AN **E-MAIL** ADDRESS WHICH YOU WOULD LIKE US TO USE? _____

ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP** _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER _____ **WORK PHONE** _____

SPOUSE OR **PARENT'S** NAME _____ **EMPLOYER** _____ **WORK PHONE** _____

PERSON TO **CONTACT** IN CASE OF AN **EMERGENCY** _____ **PHONE** _____

WHOM MAY WE THANK FOR **REFERRING** YOU? _____

RESPONSIBLE PARTY

NAME OF **PERSON RESPONSIBLE** FOR THIS ACCOUNT _____ **RELATIONSHIP TO PATIENT** _____

(IN THE CASE OF CHILDREN OF DIVORCED PARENTS, WE CONSIDER THE PARENT WHO BRINGS THE CHILD TO OUR OFFICE TO BE THE RESPONSIBLE PARTY.)

ADDRESS (IF DIFFERENT) _____ **HOME PHONE** _____

EMPLOYER _____ **OCCUPATION** _____ **WORK PHONE** _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

FOR OUR PATIENTS WITH DENTAL INSURANCE, WE EXPECT PAYMENT OF COPAYS AND DEDUCTIBLES ON THE DAY OF SERVICE.

NAME OF **INSURED** _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ **SSN** OR **SUBSCRIBER ID** _____

NAME OF **EMPLOYER** _____ WORK PHONE _____

INSURANCE COMPANY NAME _____ PHONE # _____ **GROUP #** _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE _____ CITY _____ STATE

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ **YES** ☐ **NO** **IF YES, COMPLETE THE FOLLOWING:**

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SSN OR SUBSCRIBER ID _____

NAME OF EMPLOYER _____ WORK PHONE _____

DAGHER
FAMILY DENTAL

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PATIENT MEDICAL HISTORY

PATIENT NAME_____

	YES	NO
1. ARE YOU UNDER MEDICAL TREATMENT NOW?	☐	☐
2. HAVE YOU EVER BEEN **HOSPITALIZED** FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS?	☐	☐
3. PLEASE LIST **ALL MEDICATION(S)** THAT YOU TAKE, INCLUDING NON-PRESCRIPTION _____		
4. DO YOU USE **TOBACCO**?	☐	☐
5. DO YOU HAVE A HISTORY **OF DRUG/ALCOHOL ABUSE**?	☐	☐
6. ARE YOU ON A SPECIAL DIET?	☐	☐
7. ARE YOU CURRENTLY TAKING OR HAVE TAKEN **BISPHOSPHONATES** FOR CONDITIONS OF THE BONE?	☐	☐

	YES	NO
7. ARE YOU **ALLERGIC** TO OR HAVE YOU HAD REACTIONS TO ANY DRUGS? IF YES, PLEASE SPECIFY_____	☐	☐
8. WHEN WAS YOUR LAST COMPLETE **PHYSICAL**?_____		
9. WOMEN ONLY:		
A. ARE YOU **PREGNANT** OR THINK YOU MAY BE PREGNANT?	☐	☐
B. ARE YOU NURSING?	☐	☐
C. ARE YOU TAKING **BIRTH CONTROL PILLS**?	☐	☐

10. PLEASE INDICATE WHICH OF THE FOLLOWING APPLIES TO YOU. CHECK ONLY IF ANSWER IS YES.

☐HIGH BLOOD PRESSURE	☐HEART DISEASE	☐HEART ATTACK	☐CARDIAC PACEMAKER
☐EASILY WINDED	☐AIDS OR HIV INFECTION	☐RHEUMATIC FEVER	☐HEART MURMUR
☐STROKE	☐ SWOLLEN ANKLES	☐ANGINA	☐STOMACH TROUBLE/ULCERS
☐HAY FEVER/ALLERGIES	☐HEPATITIS/JAUNDICE	☐FAINTING/SEIZURES	☐TUBERCULOSIS
☐ANEMIA	☐ASTHMA	☐ CANCER	☐SEXUALLY TRANSMITTED DISEASE
☐RADIATION THERAPY	☐ GLAUCOMA	☐EMPHYSEMA	☐ JOINT REPLACEMENT OR IMPLANT
☐ ARTHRITIS	☐RESPIRATORY PROBLEMS	☐EPILEPSY/CONVULSIONS	☐HEART TROUBLE
☐HIGH CHOLESTEROL	☐ LIVER DISEASE	☐DIABETES	☐OTHER_____

COMMENTS _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. TO THE BEST OF MY KNOWLEDGE, THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I HAVE RECEIVED A COPY OF THIS PRACTICE'S PRIVACY NOTICE. I UNDERSTAND THAT THIS PRACTICE RESERVES THE RIGHT TO CHARGE MY ACCOUNT FOR A CANCELLATION WITH LESS THAN 24 HOURS NOTICE.

X_____ _____

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