



SHUAYB DENTAL

Name \_\_\_\_\_ nickname \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Soc Sec # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home# \_\_\_\_\_

Birth date \_\_\_\_\_ Sex  M  F Cell # \_\_\_\_\_

Email \_\_\_\_\_

Minor  Single  Married  Widowed  Separated  Divorced

Employer/Occupation \_\_\_\_\_ work # \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Notify in case of emergency \_\_\_\_\_ Home# \_\_\_\_\_ Work # \_\_\_\_\_

***Person responsible for account (if patient is a minor)***

Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to patient \_\_\_\_\_ DL# \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

***Insurance information***

Name of subscriber \_\_\_\_\_  
Last First Middle

Relation to patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc Sec # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Employer \_\_\_\_\_ Work # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

## Dental History

Reason for Today's visit \_\_\_\_\_

Date of last dental x-rays \_\_\_\_\_

Check if you have any of the following:

- Bad Breath                       Grinding teeth                       Bleeding gums                       Clicking for popping jaw
- Periodontal treatment                       Sensitivity

## Medical History

Have you had any serious illnesses or operations?  No  Yes Describe: \_\_\_\_\_

Women: Are you pregnant?  No  Yes                      Nursing?  No  Yes                      Taking Birth Control Pills?  No  Yes

Check if you have any of the following:

- Artificial Joints                       Liver disease                       Hepatitis                       Hay fever
- Kidney disease                       Chemical dependency                       Tuberculosis                       High blood pressure
- Rheumatic/Scarlet fever                       Thyroid disease                       Blood transfusion                       Herpes
- Heart murmur                       Glaucoma                       AIDS/HIV positive
- Heart pacemaker                       Heart attack                       Stroke

Artificial heart valve

Other heat condition  
Describe \_\_\_\_\_

- Cancer  
 Chemotherapy/Radiation

- Arthritis, Rheumatism                       Psychiatric Care                       Hemophilia
- Latex Allergy                       Ulcers                       Tobacco habit
- Diabetes                       Asthma                       Fainting or dizzy spells
- Emphysema                       Epilepsy/seizures                       Anemia/Sickle cell disease

**List all medication you are currently taking:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List drug allergies:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Authorization & Release

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to my medical status. I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

Signature \_\_\_\_\_

Date \_\_\_\_\_