

Patient Name _____

Date of Birth _____

Sex _____

MEDICAL HISTORY

Are you now under the care of a physician? Yes No
 If yes, please explain _____
 Name of Physician _____ Phone _____
 Have you been admitted to the hospital in the past 2 years? Yes No
 If yes, please explain _____
 Have you ever had any complications following dental treatment? Yes No
 If yes, please explain _____
 Are you presently taking any medications? Yes No
 Please List _____
 Are you allergic (or had any adverse reactions) to any medications? Yes No
 Penicillin, Codeine, Aspirin, Other _____
 Are you allergic to Latex? Yes No

Have you ever had any of the following? Check those that apply:

- Heart Attack
- Chest Pain
- Congenital Heart Defect
- Heart Murmur
- High Blood Pressure
- Mitral Valve Prolapse
- Pacemaker
- Rheumatic Fever
- Stroke
- Swollen Ankles
- Diabetes
- Thyroid Disorders
- Cortisone medicine
- Bleeding disorders
- Tuberculosis
- Emphysema
- Asthma
- Shortness of Breath
- Sinus Problems
- Artificial Heart Valve
- Artificial Joints
- Muscular Disorders
- Kidney Problems
- Venereal Disease
- Drug/Alcohol Dependency
- Anorexia/Bulimia
- Organ transplant
- Anticoagulants
- Nervous Disorder
- Epilepsy
- Psychiatric Treatment
- Nervous/Anxious
- Fainting spells
- Bone Disorders
- Liver Disease/Hepatitis
- Cancer/Tumors
- Chemotherapy
- Radiation Therapy
- Learning Disability
- Hearing Impaired
- HIV positive/AIDS
- Removal of Spleen

Does your physician have you premedicate before dental appointments? Yes No
 Do you smoke or use tobacco products? _____ packs/day for _____ years Yes No
 Do you drink alcoholic beverages? _____ drinks/month Yes No
 Do you have any other disease, condition, or problem not listed? Yes No
 If yes, please explain _____
 Women, are you Pregnant? Yes, ___months/No Nursing? Y/N Birth Control? Y/N

DENTAL HISTORY

Date of Last Dental Visit _____ Reason for this visit _____

Consent for Services

If you must change your appointment time, please give a **48 hour** notice as this time has been reserved specifically for you. We understand things do come up; therefore, we allow for one missed appointment. Any missed appointments after that will be charged a \$25 fee. Thanks for your understanding.

Financial arrangements must be made in advance of treatment rendered. I understand that my 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 dependents'. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand payment is due at time of service, unless prior financial arrangements have been made. I understand a service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I agree to pay any cost accrued in the collection of my account. I waive all rights of exemption under the Constitution and laws of the State of Alabama. I authorize Jayme Mashayekh, DMD, to receive and exchange credit information.

We wish all our patients who carry dental insurance to know that all services provided are charged directly to the patient and that he or she is personally responsible for payment. We will help prepare insurance forms or assist in collections from insurance companies. However, we will NOT render our services on the assumption that our charges will be paid by an insurance company. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

I consent to the diagnostic procedures and treatment deemed necessary by the dentist for proper dental care. I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian

Date

Relationship to Patient