My Dentist

Welcome To My Dentist!

Patient's Name: _____ Date: _____/_____/_____

I hereby authorize Dr. Ziad G. Rhayem and whomever he may designate as his assistants and associate dentists, to perform upon me the required services, operation, and/or procedures initially discussed and listed in the treatment record. I understand that was only a tentative treatment plan based on the initial exam, and that changes may occur as services are rendered.

I request and authorize them to do whatever they deem advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling in their judgment for procedures in addition to or different from those initially contemplated.

I consent to the administration of local anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is always an element of risk inherent in the administration of any drug or anesthesia. This risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, and thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves, which may be caused by injections of any medications or drugs.

I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In dentistry, the most common of these complications include post-operative bleeding, swelling or bruising discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, nerve disturbances (e.g. numbness in mouth, tongue, and lip tissues), jaw fractures, sinus exposure and swallowing or aspiration of teeth and restoration, and small root fragments remaining in the jaw which might require extensive surgery for removal.

I realize that in spite of the possible complications and risks my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the operation procedure. However, I will be given full attention to my concerns should their be any that surface along the course of the treatment. Every effort will be made personally by either the managing dentist or the administrative dentist to smooth all professional issues.

I have provided as accurate and complete a medical and personal history as possible including those antibiotics, drugs, medications, foods, metals and/or substances to which I am allergic. I will follow any and all instructions as explained and directed to me, and permit prescribed procedures.

I understand that I am the only person responsible for the outcome of delaying or neglecting the recommended treatment or surgery. It is my responsibility as well to ask questions. It is my right to receive answers and responsive explanations about my dental condition and about the contemplated and alternative treatment and procedures and their risk and potential complications.

☐ Patient ☐ Guardian ☐ Parent: _____ Sign: _____

Witness Name: _____ Witness Sign: _____

Health Questionnaire

My Dentist

Medical History

		Yes	No
1.	Are you now under the care of a physician? Give name of physician and phone number _____		
	_____	Yes	No
2.	Have you ever had any serious illness or operation including cosmetic implant surgery? If so, please describe _____	Yes	No
3.	Are you taking any medicine If so, what? _____	Yes	No
	_____		
4.	Have you ever been pre-medicated with antibiotics for your dental treatment?	Yes	No
5.	Are you sensitive or allergic to: ☐ Penicillin; ☐ Erythromycin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; ☐ Latex; ☐ Other, Please list: _____		
6.	Do you have or have you had any of the following:		

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
Mitral Valve Prolapse (**MVP**)	☐	☐	Asthma	☐	☐	Stomach Ulcers	☐	☐	Kidney Disease	☐	☐	Cancer	☐	☐
Heart Murmur	☐	☐	Tuberculosis (**T.B.**)	☐	☐	Cold Sores	☐	☐	Liver Disease	☐	☐	Tumors or Growths	☐	☐
Rheumatic Fever	☐	☐	Herpes	☐	☐	Bruise Easily	☐	☐	Respiratory Disease	☐	☐	Chemotherapy	☐	☐
Joint Replacement	☐	☐	Jaundice	☐	☐	Sinus Trouble	☐	☐	Sickle Cell Disease	☐	☐	Radiation Treatment	☐	☐
Artificial Prosthesis	☐	☐	Hepatitis A B C (**Circle I**)	☐	☐	Difficulty in Swallowing	☐	☐	Blood Disease	☐	☐	Other	☐	☐
Glaucoma	☐	☐	Venereal Disease (**e.g. Syphilis, Gonorrhea**)	☐	☐	Pain in Jaw Joint	☐	☐	Mental Disorder	☐	☐	_____		
Diabetes	☐	☐	HIV Positive	☐	☐	Allergies or Hives	☐	☐	Cerebral Palsy	☐	☐	_____		
High Blood Pressure	☐	☐	Acquired Immune Deficiency Syndrome (**AIDS**)	☐	☐	Emphysema	☐	☐	Epilepsy or Seizure	☐	☐	_____		
Heart Condition	☐	☐				Arthiritis	☐	☐	Nervous Disorders	☐	☐			
Stroke	☐	☐				Psychiatric Treatment	☐	☐	Fainting Spells	☐	☐			
Excess Bleeding	☐	☐				Cortisone Medicine	☐	☐	Head Injuries	☐	☐			
Hemophilia	☐	☐	Blood Transfusion	☐	☐	Thyroid Disease	☐	☐	Leukemia	☐	☐			

		Yes	No
7.	Are you taking any recreational drugs (marijuana, cocaine, etc.)? Do you have any drug addiction? _____	Yes	No
8.	Are you taking any blood thinner medicine?	Yes	No
9.	Have you taken FEN-PHEN or REDUX or PONDIMIN?	Yes	No
10.	Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, when? _____	Yes	No
11.	Do you have any disease, condition or problem not listed that you think I should know about? If so, explain: _____	Yes	No
12.	(Women) Are you pregnant? If so how many months	Yes	No
13.	(Women) Do you take birth control pills?	Yes	No

Dental History

		Yes	No
1.	Have you ever had a local anesthetic (Novocaine, etc.)?	Yes	No
2.	Have you ever had any unfavorable reaction form a local anesthetic?	Yes	No
3.	Have you ever had any serious trouble associated with any previous dental treatment? If so, explain: _____	Yes	No
4.	How long since your last full mouth X-Rays? _____		
5.	How long since your last Dental Treatment? _____		
6.	Does dental treatment make you nervous? If yes, how much: ☐ Slightly ☐ Moderately ☐ Extremely	Yes	No
7.	Do you dislike the numb feeling that lingers after you receive local anesthetic?	Yes	No
8.	Would you be interested in a product that brings you back to normal sensation in half the time?	Yes	No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

Date____/____/____ **Signature** _____

Year 2

Changes in Health _____

Date____/____/____ **Signature** _____

Year 3

Changes in Health _____

Date____/____/____ **Signature** _____

Health Questionnaire MUST be updated every year!

Reviewed By

_____

Year 1

_____

Year 2

_____

Year 3

DO NOT WRITE IN THIS SPACE

	Year 1	Year 2	Year 3
Date			
BP	/	/	/
Pulse			
Temp			
By			

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient including x-rays. I have been informed of all possible complications of the procedures, anesthetics and /or drugs. I also acknowledge that I have been provided by display a copy of **DENTAL MATERIALS FACT SHEET** adopted on October 17, 2001, as well as a copy of the **NOTICE OF PRIVACY PRACTICES** taking effect on April 14, 2003, copies of which will be given to me upon my request. All services are rendered and accepted under the term of conditions printed on the reverse hereof.

Signed: _____ Date: ____/____/____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient: _____

My Dentist

Patient Information

PATIENT Name_____ Birth Date____/____/____

Referred by _____

If patient is a minor, give parent's or guardian's name _____ Relationship _____

□ Male □ Female Marital Status: □ Single □ Married □ Divorced □ Widowed

Address _____ City _____ State _____ Zip _____

S.S. # ___-___-___ Cell Phone # ___-___-___ Home Phone # ___-___-___

Employer _____ Position _____ Bus. Phone # ___-___-___

Bus. Address _____ City _____ State _____ Zip _____

Who should be notified in case of an emergency _____ Phone # ___-___-___

Name of nearest relative not living with you _____ Phone # ___-___-___

Purpose of this appointment _____

SPOUSE OR PARENT Name_____ Birth Date____/____/____

Employer _____ Position _____ Bus. Phone # ___-___-___

Bus. Address _____ City _____ State _____ Zip _____

S.S. # ___-___-___ Cell Phone # ___-___-___

INSURANCE INFORMATION Do you have insurance? □ Yes □ No If yes, complete the following

Name of insured _____ S.S. # ___-___-___ Relationship _____

Birth Date____/____/____ Insurance Company _____ Group No. _____

Is patient covered by other Insurance? □ Yes □ No If yes, complete the following

Name of insured _____ S.S. # ___-___-___ Relationship _____

Birth Date____/____/____ Insurance Company _____ Group No. _____

TERMS & CONDITIONS

As a condition of treatment by this office, I understand financial arrangement must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangement, must be paid for in cash at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

A service charge of 1½ % per month (18% per annum), (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

I understand that the fee estimate listed for this dental case can only be extended for a period of six months from the date of patient's examination.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or his staff, I agree to pay, therefore, the reasonable value of said services to said Doctors, or his assignee at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above donations of treatment and agree to their content.

Signed _____ Date _____/_____/_____

Pharmacy Information

As per regulation, starting January 3, 2022, we will be submitting prescriptions electronically. Please provide front desk with the following information:

Preferred Pharmacy Name:_____

Pharmacy Address:_____

Appointments

Appointments are necessary to ensure that each of our patients receives the appropriate attention and level of comprehensive care he or she needs. Please note that we can only schedule one patient per family per day. No back to back appointments for family members. Please arrive at the appointed time, as a specific amount of time has been reserved just for your specific needs. Please use the restroom before your appointment time. If you are running late please do us the courtesy of letting us know as soon as possible. If you arrive more than 15 minutes past your appointment we will do our best to accommodate you however, there is a chance we will have to reschedule.

Please provide the front desk with valid credit card information. This information will be kept confidential in your file. If you are unable to keep a scheduled appointment, we ask that you provide our office with at least 48 hours notice so that your previously reserved time can be given to another patient in need. ***No shows will be charged $45 per 30 minutes of scheduled appointment time.***

Initial: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other _____			
Cardholder Name (as shown on card): _____				
Card Number: _____				
Expiration Date (mm/yy): _____				
Cardholder ZIP Code (from credit card billing address): _____				

I, _____, authorize Future Dental Care to charge my credit card above for broken appointments. I understand that my information will be saved to file for any future broken appointments ONLY.

_____ _____

Signature Date