

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Date _____ Phone (____) _____ Alt. Phone (____) _____

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____
 Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (____) _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (If different from patient's) _____ Phone (____) _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone (____) _____

Insurance Company _____ Soc. Sec. # _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Dental History

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? _____ How often do you brush? _____

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Have you had any serious illnesses or operations? Yes No If yes, describe _____

Have you ever had a blood transfusion? Yes No If yes, give approximate dates _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have or have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |

MEDICATIONS: List medications you are currently taking:

ALLERGIES

Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____ Date

Please print name of Patient, Parent, Guardian or Personal Representative _____ Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Wissam S. Ayoub DDS
18800 Main Street, Suite 203
Huntington Beach Ca, 92648

We are committed to providing you with optimum dental care and excellent customer service. To achieve these goals, we greatly depend on your cooperation and your understanding of our office policies. Thank you for choosing us and for taking time to carefully review the following.

Appointments

Your Appointment time is reserved specially for you. We respect your busy schedule and make every effort to see you on time. Please help us achieve this goal by being punctual for your visit. A minimum of 2 business day notice is required if you are unable to keep your scheduled appointment. A broken appointment or late cancellation may result in a charge and/or refusal of further care in our office. _____ (initial)

Financial Issues

Uninsured Patients: If you are not insured, full payment for services rendered is expected the day of appointment. We accept cash, personal checks, debit, Visa, MasterCard, Discover and American Express. Or we can help you make financial arrangements through Care Credit. We apply a \$30.00 charge for returned checks. _____(Initial)

Insured Patients: If you are insured, as a courtesy to you, we will gladly submit your insurance claims on your behalf. However, we expect and appreciate payment of any deductibles and/or estimated charges not covered by your insurance at the time of each visit. We accept cash, debit, Visa, MasterCard, Discover and American Express. Or We can help you make financial arrangements though Care Credit. If for any reason your insurance does not pay, please be advised that you are ultimately responsible for the unpaid charges. This agreement shall not be amended orally. Please provide us with as much information about your plan(s) as possible prior to your first appointment and of any insurance changes that occur. This will assist us in preparing a rough estimate of your anticipated out of pocket expenses before beginning treatment. We apply a \$30.00 charge for any returned checks. _____(initial)

Authorization and Release

The patient/guardian who is signing this form is responsible for all account transactions and balances. Outstanding balances over 60 days shall accrue interest at the rate of 18% annually. If insurance is involved: I authorize payment directly to WISSAM AYOUB D.D.S. I authorize all credit inquiries deemed necessary in connection with my account.

I understand and accept all of the above Appointment and Payment Policies

Print Name _____

Responsible Party Name _____

Signature _____ Date _____