ULTIMATE DENTAL
SAMMI HADAD, DDS

Patient Information

TODAY'S DATE: _____

PATIENT NAME: _____

Patient birthdate: _____ SSN#: _____

Home phone: _____ Cellular phone: _____

Email address: _____ May we text or email appt. reminders to you? ◯ Yes ◯ No

Address: _____

City: _____ State: _____ ZIP: _____

Please check approriate box: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Minor patient's parent/guardian name: _____

Guardian's Work phone: _____

Business Address: _____

City: _____ State: _____ ZIP: _____

Spouse Name: _____ Employer: _____ Work Phone: _____

If Patient is a Student, Name of School/College: _____

City: _____ State: _____ ZIP: _____

EMERGENCY CONTACT NAME: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Responsible Party

Name of person responsible for this account: _____

Relationship to patient: _____

Home phone: _____ Work phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

Employer: _____

Is this person currently a patient in our office? ◯ Yes ◯ No

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Insurance Information

Primary Insurance Information

Name of Insured: _____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured birthdate: _____ Insured SSN #: _____

Employer: _____ Union or Local #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance Company: _____

Group #: _____ Subscriber ID #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Secondary Insurance Information

Name of Insured: _____

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured birthdate: _____ Insured SSN #: _____

Employer: _____ Union or Local #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Insurance Company: _____

Group #: _____ Subscriber ID #: _____

Address: _____

City: _____ State: _____ ZIP: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance covered with NAME OF INSURANCE COMPANY and assign directly to ULTIMATE DENTAL 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 my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature | Relationship | Date

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Patient Medical History

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you.

Are you under a physician's care now? .....❍ Yes ❍ No If yes, explain: _____

Have you ever been hospitalized or had a major operation? .....❍ Yes ❍ No If yes, explain: _____

Have you ever had a serious jaw, head or neck injury? .....❍ Yes ❍ No If yes, explain: _____

Are you taking ANY medications, pills, or drugs (including OTC)? .....❍ Yes ❍ No If yes, explain: _____

Have you ever been advised to take medication prior to dental visits? ....❍ Yes ❍ No Comments: _____

Do you currently use tobacco (chewing or smoking)? .....❍ Yes ❍ No _____

PHYSICIAN NAME: _____ **PHONE:** _____ **DATE OF LAST EXAM:** _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

❍ Aspirin ❍ Penicillin ❍ Codeine ❍ Acrylic

❍ Metal ❍ Latex ❍ Local Anesthetics

❍ Other (please explain): _____

_____

FOR WOMEN ONLY

Are you pregnant or trying to get pregnant? .....❍ Yes ❍ No

Are you taking oral contraceptives? .....❍ Yes ❍ No

Are you nursing? .....❍ Yes ❍ No

_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

Rheumatic Fever	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Arthritis/Rheumatism	❍ Yes ❍ No
Heart Murmur	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No
Cardiac Pacemaker	❍ Yes ❍ No	Heart Attack	❍ Yes ❍ No	STD(s)	❍ Yes ❍ No
Heart Surgery	❍ Yes ❍ No	(When? _____)		Irregular Heart Beat	❍ Yes ❍ No
Heart Disease	❍ Yes ❍ No	Stroke	❍ Yes ❍ No	Jaundice	❍ Yes ❍ No
Congenital Heart Disorder	❍ Yes ❍ No	Surgical Pins or Plates	❍ Yes ❍ No	Stomach Ulcers	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Respiratory Problems	❍ Yes ❍ No
Mitral Valve Prolapse	❍ Yes ❍ No	Kidney Disease	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Artificial Joint(s)	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No	Allergies/Hayfever	❍ Yes ❍ No
Diabetes	❍ Yes ❍ No	Anemia	❍ Yes ❍ No	Thyroid Condition	❍ Yes ❍ No
AIDS/ARC/HIV Infection(s)	❍ Yes ❍ No	Epilepsy/Convulsions	❍ Yes ❍ No	Bleeding Problems	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	Fainting/Seizures	❍ Yes ❍ No	Recent Weight Loss	❍ Yes ❍ No
Radiation Therapy	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No	Drug Addition	❍ Yes ❍ No
Hepatitis A	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Other	❍ Yes ❍ No
Hepatitis B or C	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No	(Explain: _____)	

MEDICAL ALERTS: _____

_____

COMMENTS: _____

_____

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Patient Dental History

1. Do you have a specific dental problem? ❍ Yes ❍ No
   If yes, please explain: _____
2. Do you have dental exams on a routine basis? ❍ Yes ❍ No
   Last visit?: _____
3. Would you describe your dental health as good? ❍ Yes ❍ No
4. Do you think you have active decay or gum disease? ❍ Yes ❍ No
5. Do your gums bleed when brushing or flossing? ❍ Yes ❍ No
6. Do you brush and floss on a routine basis? ❍ Yes ❍ No
7. Do you feel nervous about having dental treatment? ❍ Yes ❍ No
8. Have you ever had a bad experience in a dental office? ❍ Yes ❍ No
   Please explain: _____
   _____
9. Do you want to keep your remaining teeth? ❍ Yes ❍ No
10. Do you like your smile? ❍ Yes ❍ No
    Why?: _____
11. Name of previous dentist (optional): _____
12. Are your teeth sensitive to hot or cold liquids/food? ❍ Yes ❍ No
13. Do you feel pain to any of your teeth? ❍ Yes ❍ No
14. Do you have any sores or lumps in or near your mouth? ❍ Yes ❍ No
15. Do you have frequent headaches? ❍ Yes ❍ No
16. Do you clench or grind your teeth? ❍ Yes ❍ No
17. Do you bite your lips or cheeks frequently? ❍ Yes ❍ No
18. Have you ever experienced any of the following problems in your jaw?

    A) Clicking or popping? ❍ Yes ❍ No
    B) Pain (joint, ear, side of face)? ❍ Yes ❍ No
    C) Difficulty chewing? ❍ Yes ❍ No
    D) Difficulty opening/closing? ❍ Yes ❍ No

I, the undersigned, have completed the health questionnaire and certify that the preceeding information is true and correct. ULTIMATE DENTAL WILL NOT BE HELD RESPONSIBLE FOR ANY PROBLEMS ARISING OUT OF INADEQUATE OR UNDISCLOSED INFORMATION.

_____ Patient/Guardian Signature

_____ Date

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In our practice we believe that the level of care that you want is your choice. We will help you thoroughly understand your dental choices so you can make the best possible decision. Your first choice is how you would like us to work with you. Please consider the following guidelines for care so that we can best meet your goals.

LEVEL 1: URGENT CARE
Patients at this level choose treatment only when they experience a crisis such as pain, swelling or bleeding that requires immediate treatment. Urgent care patients are generally not focused on taking steps to ensure future urgencies do not occur. They come in when they know they have a major problem to deal with, and the condition has developed to a point of urgency in order to control pain or save the tooth.

LEVEL 2: REMEDIAL CARE
Patients at this level choose treatment for obvious problems such as broken or cracked teeth, cavities, sensitivity, discomfort or concerns that are creating issues in the mouth right now. Remedial care patients are usually not focused on taking steps to prevent new concerns or improve their health over time. They only want to deal with concerns that have already developed into conditions that require treatment to remove existing disease, or repair the teeth back to the most basic level of health.

LEVEL 3: PROACTIVE CARE
Patients at this level seek treatment for existing concerns just like remedial care patients, but they are also concerned about conditions that may create problems in the near future. These patients generally want to maintain the health of each tooth at as basic level, so they also do what they can to prevent new concerns from developing. When treatment is recommended, proactive care patients usually prioritize their treatment to manage their costs, but still take care of things soon enough so that known concerns are less likely to develop into major problems.

LEVEL 4: COMPLETE DENTISTRY
Complete dentistry patients are concerned about the current conditions in their mouth, the causes of dental disease and their long-term health. They want to know their full treatment options so they can become and remain as healthy as they can be, thereby minimizing their long-term dental costs. These patients often choose a step-by-step master plan focused on restoring their health, combined with prevention and regular care to achieve steady long-term dental health and an improved appearance to their smile over time.

LEVEL 5: OPTIMAL DENTISTRY
Just like complete dentistry patients, patients at this level are focused on long-term dental health and disease prevention, but they also want their teeth and smile to look great. Patients at this level are interested in treatment options to correct all dental concerns for lifelong optimal function and appearance. For some of these patients, enhancing their appearance with a beautiful new smile is very important.

It is not uncommon for people to begin at one level and progress to higher levels when they are ready. We're here to help you discover what is right for you so your teeth, smile and mouth remain as healthy as they can be for life based on your goals.