PETER F. HAZIM, D.D.S.

Preventative – Restorative – Cosmetic Dentistry

Patient Information

Date: ___________Home Phone:________________Work Phone:________________Cell:_________________

Name: ____________________________________ Social Security Number _________- _________- ________

Address: _______________________________________City: _______________State: _________Zip: _________

Sex ☐M ☐F Birth date: _______________ ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Patient Employed By: __________________________________Business Address: ________________________

Whom may we thank for referring you: ____

In case of emergency who should be notified: ____

Responsible Party

Name of person responsible for the account: __________________________ Phone: ____________________

Address of responsible party: __________________________City: __________State: _____Zip: ___________

Relationship to the Patient: _________________ Birth Date: ___________SSN: _______- _______- ________

Dental Insurance Information

Name of the Insured: ________________________________ Relationship to Patient: ___________________

Insured's Date of Birth: ____________ SSN: ______- _______- ________Employer: _____________________

Insurance Company: ____________________________________ Phone: ______________________________

Group Number: ___________________________ Employee Identification Number: ____________________

Insurance Company Address: __________________________City: ____________State: ____Zip: __________

Do you have Secondary Insurance Coverage: Yes ☐ No☐ If yes, please complete the following information:

Name of the Insured: ________________________________ Relationship to Patient: ___________________

Insured's Date of Birth: ____________ SSN: ______- _______- ________Employer: _____________________

Insurance Company: ____ Phone: _________________________

Group Number: _________________________ Employee Identification Number: ______________________

Insurance Company Address: ______________________________City: ____________State: ____Zip: _______

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental 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.

Signature of Patient or Parent/Guardian if Minor:____ Date: __________________

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Patient Information

Patient Name:____

I, the patient, (parent or guardian), have made a contract with my insurance company to provide for third party reimbursement for my dental care. As the patient, (parent or guardian), I understand that I am responsible for understanding and complying with my insurance benefits, limitations, and exclusions. I understand that I am financially responsible for any non-covered charges.

I also understand and agree to pay any remaining balance following insurance payment. If for any reason my account with Dr. Peter Hazim is placed with a collection agency, I will be responsible for any fees which are added to the debt due to the collection process. I also agree to pay a $25 convenience fee for any returned checks.

I, the patient, agree to arrive on time for my appointment. I understand that this time is reserved especially for my benefit. I understand that without 24 hours notice of cancellation, I will compensate Dr. Peter Hazim at $65 for time lost on my account.

Signature of Patient or Legal Guardian:____

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Dental History

Name: ____

Reason for today's visit: ____

When was your last dental visit: ____

How often do you brush your teeth: ____

What texture toothbrush do you use: Soft ☐ Medium ☐ Hard ☐

****Please circle and answer for <u>each</u> question listed below:***

Do you feel pain in any of your teeth when brushing or flossing? Yes No

Do your gums bleed when brushing or flossing them? Yes No

Are your teeth sensative to hot, cold, sweet or sour foods? Yes No

Have you noticed any loosening of your teeth? Yes No

Does food tend to become caught between your teeth? Yes No

Do you have any sores or lumps in or near your mouth Yes No

Have you ever experienced any of the following problems in your jaw?
Clicking: Yes No
Pain (joint, ear, side of face): Yes No
Difficulty opening/closing: Yes No

Have you had any head, neck, or jaw injuries? Yes No

Do have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had:
Orthodontic treatment? Yes No
Oral Surgery? Yes No
Your teeth ground or your bite adjusted? Yes No
Worn any type of bite plate or appliance? Yes No

Are you satisfied with the appearance of your teeth? Yes No

Is there anything about having dental treatment that bothers you? Yes No

Medical History

Are you in good health? Yes No

Have there been any changes in your general health within the past year? Yes No

When was your last physical exam?__________________ Yes No

Are you now under the care of a physician? Yes No
Physician's Name:____
Address:____
Telephone:____

Have you ever been hospitalized? If yes, please explain Yes No

____

Are you currently taking any medication(s), including nonprescription medicine(s), diet pills or herbs? Yes No
If yes, list here: ____
____
____

Have you ever taken Phen Fen? Yes No

Do you bruise easily? Yes No
Have you had any abnormal bleeding? Yes No
Have you ever required a blood transfusion Yes No

Do you use tobacco? Yes No
Do you use alcohol? Yes No
Do you use cocaine or other drugs? Yes No

Are you wearing contacts lenses? Yes No

Do you have any disease, condition, or problem not listed above that you think I should know about?_____________________ Yes No

Are you allergic to or have you had a reactions to:
Local anesthetics like novacaine: Yes No
Penicillin: Yes No
Sulfa Drugs: Yes No
Barbiturates, Sedatives, or Sleeping pills: Yes No
Aspirin: Yes No
Iodine: Yes No
Latex: Yes No
Other Allergies: ____

Medical History

Patient Name:____

Do you have, or have you ever had, any of the following:

Rheumatic heart disease or rheumatic fever:	Yes	No
Scarlet Fever	Yes	No
Heart defect or heart murmur	Yes	No
Heart trouble, heart attack, or angina	Yes	No
Do you have pain in your chest upon exertion	Yes	No
Are you ever short of breath after mild exercise	Yes	No
Do your ankles swell	Yes	No
Pacemaker	Yes	No
Heart Surgery	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Hepatitis	Yes	No
Jaundice	Yes	No
Liver Disease	Yes	No
Stroke	Yes	No
Lung or Breathing Problems	Yes	No
Asthma	Yes	No
Hay Fever	Yes	No
Hives or Skin Rash	Yes	No
Fainting Spells or Seizures	Yes	No
Diabetes	Yes	No
Sinus Trouble	Yes	No
Thyroid Problems	Yes	No
Allergies	Yes	No
Osteoporosis	Yes	No
Joint Replacement or Implant	Yes	No
Stomach Ulcer	Yes	No
Kidney Trouble	Yes	No
Tuberculosis	Yes	No
Persistent Cough	Yes	No
Cough that produces blood	Yes	No
Cancer	Yes	No
STD	Yes	No
AIDS or HIV Infection	Yes	No
Epilepsy	Yes	No
Anemia	Yes	No
Leukemia	Yes	No
Glaucoma	Yes	No
Eating Disorder	Yes	No

Women Only

Are you pregnant or think you may be	Yes	No
Are you nursing	Yes	No
Are you taking birth control	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

*Signature of Patient, or Guardian*____

For completion by Doctor

Summary of Dental and Medical History: ____

____

Medical History Update:

Date	Comments	Patient	Dentist	Hygienist
_________	____	______	______	_________
_________	____	______	______	_________
_________	____	______	______	_________
_________	____	______	______	_________