Thank you for visiting Dr. Makram's office today. We want your visit to be pleasant and comfortable. Please help us by completing this form.

PATIENT INFORAMTION

Name _____
Last First MI (Preferred Name)

Gender M □ F □ Marital Status S □ M □ D □ W □ Date of Birth_____

Address _____
Street

_____
City City Zip

Employer: _____ Occupation _____

Drivers License _____ Social Security # _____

Phone: Home ( ) _____ May we contact you at home? Y □ N □

Work ( ) _____ May we contact you at work? Y □ N □

Mobile ( ) _____ May we contact you on your mobile? Y □ N □

E-Mail _____ May we contact you via e-mail? Y □ N □

Emergency Contact _____
Name Relationship Telephone

Primary Dental Carrier

Subscriber Name: _____ Social Security # _____

Relationship to Patient: Self □ Spouse □ Parent □ Date of Birth_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Secondary Dental Carrier

Subscriber Name: _____ Social Security # _____

Relationship to Patient: Self □ Spouse □ Parent □ Date of Birth_____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Insurance Authorization Statement (sign & Date)

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible of all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge

Signature _____ **Date** _____

If Patient is Under 18 Responsible Party _____Relation to Patient _____
Address _____

Telephone ( ) _____ Social Security # _____

Birth Date _____ Drivers License # _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change about your smile?_____

Medical History and Information

Conditions

- □ Abnormal Bleedinn
- □ Alcohol Abuse
- □ Anemia
- □ Angina Pectoris
- □ Arthritis
- □ Artificial Heart Valve
- □ Asthma
- □ Bleeding Excessively
- □ Blood Transfusion
- □ Cancer
- □ Chemotherapy
- □ Colitis
- □ Congenital Heart Defect
- □ Diabetes
- □ difficulty Breathing
- □ Drug Abuse
- □ Emphysema
- □ Epilepsy
- □ Faciall Surgery
- □ Fainting Spells
- □ Fever Blisters
- □ Frequent Headaches
- □ Glaucoma
- □ HIV +/ Aids
- □ Heart Attack
- □ Heart Murmur
- □ Heart Surgery
- □ Hemophilia
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ High Blood Pressure
- □ Joint Replacement
- □ Kidney Problems
- □ Liver Disease
- □ Low blood Presure
- □ Mitral Valve Prolapse
- □ Pace Maker
- □ Psychiatric Problems
- □ Radiation Therapy
- □ Rheumatic Fever
- □ Seizures
- □ Sexually Transmitted Disease
- □ Shingles
- □ Sickle Cell Disease
- □ Sinus Problems
- □ Stroke
- □ Thyroid Problems
- □ Tuberculosis
- □ Ulcers

Allergies

- □ **Aspirin**
- □ **Codeine**
- □ **Dental Anesthetics**
- □ **Latex**
- □ **Metals**
- □ **Penicillin**
- □ **Sulfa**
- □ **Tetracycline**

Other _____
_____

Do you Smoke or use Tabacco?
□Y □N

If Female

□Y □N Are you taking Birth Control Pills?

□Y □N Are you Pregnant? If Yes, # of Weeks ____

□Y □N Are you Nursing?

Height _____

Weight _____

Please list any medications you are currenty taking :_____

_____

Treatment Authorisaction Form

I authorise and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia, taking the necessary x-rays, impressions and pictures as indicated. I certify to the above statements regarding my medical conditon. I understand that I am respoonsible of updating my medical history and medications changes.treatment and services rendered are my responsibility.

Patient/Guardian Signatuer _____ Date_____