



MITRI A. GHAREEB, DDS, FAGD | JOSHUA B. MASSEY, DDS | GEORGE DIRANI, DDS | BROOKE TOLLIVER, DDS | KARLEE ALDERMAN, DDS

Patient Information

First Name: _____ Initial: _____ Last: _____ Today's Date: _____
Preferred Name: _____ Gender (M/F): _____ Marital Status: _____
Date of Birth: _____ Social Security: _____ Driver's License: _____
Address: _____ City/State/ Zip: _____
Phone #'s: Home: () - Work: () - Ext: _____
Fax: () - Cell: () - _____
Email: _____ Which email is this (home, work)? _____

Referral Information

What is the name of person, office or other source referring you to our practice?

Are any of your immediate family members patients at this office? _____

If so, who? _____

Spouse or Responsible Party Information

First Name: _____ Initial: _____ Last: _____
Relationship to Patient: _____ Gender (M/F): _____ Marital Status: _____
Date of Birth: _____ Social Security: _____ Driver's License: _____
Address: _____ City/State/ Zip: _____
Phone #'s: Home: () - Work: () - Ext: _____
Fax: () - Cell: () - _____

Employment Information

Employer Name: _____ Phone: _____
Address: _____ City/State/ Zip: _____

Patient Dental Insurance

Name of Insured: _____ Relationship to patient: _____
Insured Employer: _____ Insured SS#: _____ Insured D.O.B. _____
Insured Address: _____ City/State/ Zip: _____
Insurance Carrier: _____ ID# _____ Group # _____ Plan Name: _____



Patient Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing. Revocation of this consent is only applicable from date of revocation forwards and cannot be applied to past information used or disclosed.

I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me.

I certify that all answers on my health history and patient registration information have been answered accurately to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care:

Name(s): _____

Patient Print _____ Signature _____ Date _____

If patient is a minor, Parent/Guardian Print _____ Signature _____



Financial and Dental Insurance Policy

PLEASE READ CAREFULLY

If you have dental insurance it is a contract between you, your employer and your insurance carrier.

We are not a party in this contract.

- Not all services may be covered under any given contract. Insurance companies select which services they will and will not cover; covered services may vary among different plans of the same insurance company. Our office is **NOT** responsible for contract limitations.
- As a courtesy to you, we will file your insurance claims on your behalf and assist you in maximizing your benefit. We realize that it is difficult to know exactly what your insurance company may pay towards procedures. We will do our best to estimate what the insurance company will pay based on the information they provide us. **Estimates provided before treatment are not guaranteed.**
- Your estimated portion or co-pay for treatment must be paid **at the time of service.**
- If you have secondary coverage we are willing to file that claim for you as well. However, we must have an EOB (Explanation of Benefits) and a check from the primary insurance before we can submit the secondary claim.
- Nearly all insurance policies have a maximum annual pay-out. Our office is **NOT** responsible for what benefits remain. Check with your insurance carrier to determine what benefits remain on your policy for the current year.
- If a service is not covered by your insurance, or there is a balance left on your account after your insurance has paid you will be ultimately responsible for payment and will receive a statement/bill from our office.
- We accept cash, check, all major credit cards, and Care Credit.
- Unpaid balances will be turned over to our collection agency after 90 days past the due date.
- Your balance must be paid-in-full before any removable or non-removable lab work is cemented/delivered. This includes dentures, partials, crowns, inlays, onlays, veneers, bridges, whitening trays, etc. If your insurance payment is pending you may choose to pay and be reimbursed when we receive the insurance payment.

By signing below, I acknowledge that I have read, understand and agree to honor the policies outlined above.

Patient Print _____ Signature _____ Date _____

If patient is a minor, Parent/Guardian Print _____ Signature _____



MITRI A. GHAREEB, DDS, FAGD | **JOSHUA B. MASSEY, DDS** | **GEORGE DIRANI, DDS** | **BROOKE TOLLIVER, DDS** | **KARLEE ALDERMAN, DDS**

HEALTH HISTORY

Patient Name: _____ Today's Date: _____

In Case of Emergency, Please Contact: _____

Relationship to Patient: _____ Emergency Phone Number: _____

Physician Name: _____ Physician's Phone Number: _____

Date of last exam? _____ Are you currently under medical treatment? **Y / N** If so, for what? _____

Have you been hospitalized within the last 5 years? **Y / N** If so, for what reason? _____

Have you had joint replacement surgery? **Y / N** If so, what kind and when? _____

Have you had heart surgery? **Y / N** If so, what kind and when? _____

Have you previously been diagnosed with bacterial endocarditis? **Y / N** If so, when? _____

Have you previously been diagnosed with ulcerative colitis? **Y / N** If so, when? _____

Have you been advised by a doctor to take antibiotics prior to dental treatment? **Y / N** If so, for what? _____

Are you a diabetic? **Y / N** If so, last blood sugar reading? _____ When? _____ Last HbA1c? _____

Do you use tobacco? **Y / N** If so, what kind of tobacco do you use/how many packs a day? _____

Do you drink alcohol? **Y / N** If so, how many drinks a day? _____

Do you use controlled substances? **Y / N** Do you use recreational drugs? **Y / N**

Are you pregnant or think you may be pregnant? **Y / N** Are you currently on birth control? **Y / N** Are you nursing? **Y / N**

Are you allergic to any medications? **Y / N** If so, which ones? _____

Are you currently taking blood thinners (aspirin, warfarin, etc.)? **Y / N** If so, which one and frequency? _____

Please list all other allergies: _____

Please include a list of **ALL** medications: _____

Do you have or have you had any of the following? Please circle.

- | | | | |
|------------------------|--------------------|--------------------------|---------------------|
| Alzheimer's | Diarrhea | High Blood Pressure | Rheumatic Fever |
| Anemia | Dizziness/Fainting | HIV/AIDS | Shortness of Breath |
| Arthritis | Eating Disorder | Hypoglycemia | Sinus Problems |
| Artificial Joints | Emphysema | Immune Suppression | Stomach Problems |
| Artificial Heart Valve | Epilepsy | Kidney Disease | Stroke |
| Asthma/Bronchitis | Excessive Bleeding | Latex Rubber Allergy | Swollen Ankles |
| Blood Disease | Fibromyalgia | Liver Disease | Thyroid Problems |
| Bronchitis | Glaucoma | Low Blood Pressure | Tuberculosis |
| Cancer/Chemotherapy | Growths | Mental/Nervous Disorders | Tumors |
| Chest Pain | Head Injuries | Mitral Valve Prolapse | Ulcers |
| Cough | Heart Attack | Osteoporosis | Venereal Disease |
| Depression | Heart Disease | Pacemaker | Other |
| Diabetes | Heart Murmur | Radiation Treatment | |
| | Hepatitis | Respiratory Problems | |

PLEASE TURN OVER



MITRI A. GHAREEB, DDS, FAGD | **JOSHUA B. MASSEY, DDS** | **GEORGE DIRANI, DDS** | **BROOKE TOLLIVER, DDS** | **KARLEE ALDERMAN, DDS**

HEALTH HISTORY

Name of Previous Dentist and Location: _____ Date of Last Exam: _____

What is your reason for coming to Ghareeb Dental Group: _____

How did you hear about us? _____

Have you had any trouble associated with any previous dental treatment? _____

What is your chief dental complaint? _____

How often do you brush your teeth? (circle one) **Never** | **Once a week** | **Few times a week** | **Once a day** | **Twice or more a day**

How often do you floss? (circle one) **Never** | **Once a week** | **Few times a week** | **Once a day** | **More than once a day**

What kind of toothpaste do you use? _____ What (if any) mouth rinse do you use? _____

Are your teeth sensitive to hot/cold/sweet/sour? **Y / N**

Do your gums bleed while brushing or flossing? **Y / N**

Do you feel pain in or around your teeth or gums? **Y / N** If so, please explain: _____

Do you have sores or lumps in or near your mouth? **Y / N**

Have you ever had any injuries involving your head, neck or jaw? **Y / N**

Have you ever had pain or clicking in your jaw? **Y / N**

Have you ever had difficulty in opening, closing, or chewing? **Y / N**

Do you have frequent headaches? **Y / N**

Have you had prolonged bleeding following an extraction? **Y / N** If so, please explain: _____

Have you had difficult extractions in the past? **Y / N** If so, please explain: _____

Do you clench or grind your teeth? **Y / N** If so, how often? _____

Do you like your smile? **Y / N**

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

Additional Comments: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form, and I understand the HIPPA regulatory laws.

Patient/Guardian Signature: _____ **Date:** _____