Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

PATIENT INFORMATION

Name : ……………………………………………… Address: ……………………………… City: ……………………………

State: ………… Zip …………..……Home # (….)………………Cell # (…..)…………… Work (…..) …………………………..

S.S #:…………………………………………………………………….. Birth date: ……………………………….…………

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for …years

E-mail : ……………………………………………... Cell Phone #1: (….)……………………..

Employer: …………………………………………… Employer (….)……………………………………...

Employer ……………………….................City: ………………………… State: ………... Zip: ……………..

Spouse or Parent's Name ……………………………………Employer………………………Work Phone (....)…………………..

Whom may we thank for referring you…………………………………………………………………………………….....

Person to contact in case of emergency……………………………………………………...Phone(….)………………………

RESPONSIBLE PARTY

Name of Person Responsible for this account ……………………………..…. Relation to Patient ……………………………........

Address …………………………………………………………………….. Home Phone (….)……………………………………

Cell Phone (….) ………………Birth date ………………………..

Employer ……………………………………………………………………….. Work Phone (....)……………………………………..

Currently a patient in our office? ☐ Yes ☐ No

INSURANCE INFORMATION (Primary)

Name of Insured ……………………………………………DOB: ………………………. Relation to Patient ……………………

Employer…………………………………………………………………….. Work Phone (….)……………………………………...

Employer Address ……………………………………………..... City…………………….. State…………………..Zip…………...

Insurance Company ……………………………………………..… Group #..........................Member ID #: …………………………

Address …………………………………………………………City ……………………State …………………Zip …………

If minor Name of School: ………………………………………………………………………………………………...

ADDITIONAL INSURANCE (Secondary)

Name of Insured ……………………………………………DOB : ………………………. Relation to Patient ……………………

Employer…………………………………………………………………….. Work Phone (….)……………………………………...

Employer Address ……………………………………………..... City…………………….. State…………………..Zip…………...

Insurance Company ……………………………………………..… Group #..........................Member ID #: …………………………

Address …………………………………………………………..… City ……………………State …………………Zip ……………..

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:

- □ Bad breath
- □ Bleeding gums
- □ Clicking or propping jaw
- □ Sensitivity to cold
- □ Grinding teeth
- □ Loose teeth or broken fillings
- □ Periodontal treatment
- □ Sores or growths in your mouth
- □ Sensitivity to hot
- □ Sensitivity to sweets
- □ Food collection between the teeth

How often do you floss? ………………………………………… How often do you brush? ....

MEDICAL HISTORY

Physician's Name ………………………………………………… Date of last visit ………………………………………
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 ever taken or currently taking bisphosphonate drugs □ 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 had problems with any of the following:

- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Artificial Joints, Pins, etc
- □ Asthma
- □ Back Problems
- □ Bleeding Abnormally
- □ Blood Disease
- □ Cancer
- □ Chemical Dependency
- □ Chemotherapy
- □ Circulatory Problems
- □ Congenital Heart Lesions
- □ Cortisone Treatments
- □ Cough, Persistent
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Headaches
- □ Heart Murmur
- □ Heart Problems
- □ Hemophilia
- □ Hepatitis
- □ Hernia Repair
- □ High Blood Pressure
- □ HIV/AIDS
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Mitral Valve Prolapse
- □ Pacemaker
- □ Psychiatric
- □ Radiation Treatment
- □ Respiratory Disease
- □ Rheumatic Fever
- □ Scarlet Fever
- □ Shortness of Breath
- □ Skin Rash
- □ Stroke
- □ Swelling of Feet or Ankles
- □ Thyroid Problems
- □ Tobacco Habit
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease
- □ Latex Allergy

List Medications you are currently taking and the correlating diagnosis :
……………………………………………………………………………………
……………………………………………………………………………………

Allergies :
………………………………………………………………
………………………………………………………………

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.
I certify that I, and/or my dependent(s), have insurance coverage with ……………………………………….…and assign directly to
Name of Insurance Company (ies)
Dr.Ghada S Massabni 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 payable for related services.

…………………………………………………………………………
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

Ghada S. Massabni, D.M.D., D.D.S.
Family, Cosmetic and Laser Dentistry

Fear Questionnaire

Patient's name…………………….Sex……….Age………Date…………………………..

Instructions: Below is a list of situations and experiences that sometimes cause people to become fearful or anxious in varying degrees. Please circle one of the numbers to the right that best describes the amount of fear or anxiety you have felt in the past and up until today. Circle only one.

0- Not at all 1- A little bit 2- Moderately 3- Markedly 4- Severely

To what extent do you fear or avoid the following:

1-Thought of the dental visit before the actual appointment	0	1	2	3	4
2-Being trapped in the dental chair	0	1	2	3	4
3-Waiting in the dentist chair	0	1	2	3	4
4-Fear of being alone	0	1	2	3	4
5-enclosed or confined spaces	0	1	2	3	4
6-Traveling on buses, subways, cars	0	1	2	3	4
7-Noise of the dental drill	0	1	2	3	4
8-Going far from home	0	1	2	3	4
9-Eating, drinking or writing in public and being watched or the focus of attention	0	1	2	3	4
10-Not being informed by the dentist as to what is to be done	0	1	2	3	4
11-Needles in the mouth	0	1	2	3	4
12-Repetition of a past bad dental experience	0	1	2	3	4
13-Reading or hearing about health topics or disease	0	1	2	3	4
14-Crowded places such as stores, social gatherings, meetings, theaters	0	1	2	3	4
15-Dental Instruments and procedures	0	1	2	3	4
16-Places, things, or activities other than those listed	0	1	2	3	4

Ghada S. Massabni, D.M.D., D.D.S.
Family, Cosmetic and Laser Dentistry

To our Patients

We would like to welcome you to our office and thank you for selecting us to help you with your dental needs. The goal of our practice is to provide the highest quality dental care in a comfortable, professional atmosphere with mutual understanding and communication so we can build a long term relationship. Please take a few moments to review our office procedures.

Appointment times: It is very important that you understand that this is the time set aside especially for you. Appointments should be made when you know they can definitely be kept. A 48 hours notice for cancellations will be acceptable; this will allow us to call another patient who may be waiting for an appointment. A charge will be applied to your account after your second consecutive broken appointment.

Dental Insurance: If you have dental insurance we will gladly process your claim for you but please remember it is your responsibility to understand your dental coverage as it is a benefit made for you thru your employer. We will help you to maximize your benefits and co-payments will be collected at your visit.

Payment Policies: payment for services rendered will be collected at that time. We ask that your account be paid in full before scheduling future office visits. If there is dental insurance, deductibles and co-payments will be collected. Financial arrangements can be made for large cases involving multiple visits. We accept cash, checks, visa, mastercard, and discover-sorry no American express.

I have read, understand and accept the above business practices.

Patient: ……………………………………………………. Date: …………………