

**BARBAG DENTAL ASSOCIATES**

9172 GLADES ROAD  
BOCA RATON, FLORIDA 33434  
561-483-5775

**PERSONAL INFORMATION**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Home Phone \_\_\_\_\_  Male  Female Birth Date \_\_\_\_\_  
Social Security # \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Occupation \_\_\_\_\_ How long employed \_\_\_\_\_  
Parents name if minor or student \_\_\_\_\_  
Address if different from above \_\_\_\_\_  
Who may we thank for referring you? \_\_\_\_\_  
In the event of an emergency who should we contact? Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

So that no misunderstandings arise, we wish to inform you of our payment policy. Payment for services is expected at the time of your visit. If this presents a problem, the front desk will work with you in order to make an arrangement. We will do all we can to help you with your insurance coverage. Regardless of insurance coverage of pre-determinations, all amounts due remain your obligation until paid in full. For any unpaid balance that remains after your treatment is completed (that is determined by the insertion date of bridgework, crowns or dentures) a service charge of 1 1/2 % per month (18% per annum) will be added to your account. Kindly acknowledge acceptance of this policy by signing and dating this form below.

\_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_

**Barbag Dental Associates  
 Boca Lyons Center  
 9172 Glades Road  
 Boca Raton, Florida 33434  
 (561) 483-5775**

**Medical and Dental History**

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 that you will be receiving. Thank you for answering the following questions.

PLEASE PRINT

YES    NO

Name \_\_\_\_\_

1. Have you ever been hospitalized for major operations or serious illness?    

If so, what \_\_\_\_\_  
 \_\_\_\_\_

3. Are you under any medical treatment now?    

4. Have you had any allergic reactions to any drug including penicillin, codeine, novocaine, and aspirin? If so what?       
 \_\_\_\_\_  
 \_\_\_\_\_

5. Has there been a change in your health in the past year?       
 \_\_\_\_\_  
 \_\_\_\_\_

6. Have you ever had a blood transfusion?    

7. Have you ever had abnormal bleeding problems after a cut or tooth extraction?    

8. Are you now taking drugs or medications? Please list them       
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Have you ever had surgery to replace a joint with a prosthesis?    

10. Do you smoke or use tobacco products?    

11. Has a physician ever informed you that you had:

	Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>
Heart Ailment	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Daily Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>

**OVER →**

	Yes	No		Yes	No
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stomach or			Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Prosthetic Joint	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis or Yellow			Latex Allergy (e.g.		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	to latex gloves)	<input type="checkbox"/>	<input type="checkbox"/>

12. Women:

Are you taking birth control pills?

YES NO

Are you pregnant?

Are you nursing?

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

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 staff, responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**MEDICAL HISTORY UPDATE:**

**Date**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Comments**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**We do not accept insurance but we will gladly fill out a form for you. Please fill in the following information:**

**DENTAL INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**ADDITIONAL INSURANCE**

Name of Insured \_\_\_\_\_

Name of Insured \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Birthday \_\_\_\_\_

Insured's Birthday \_\_\_\_\_

Social Security # \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employer Phone # \_\_\_\_\_

Employer Phone # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Group # \_\_\_\_\_

Group # \_\_\_\_\_

Employee/Cert. # \_\_\_\_\_

Employee/Cert. # \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

Ins. Co. Phone # \_\_\_\_\_

Deductible \_\_\_\_\_

Deductible \_\_\_\_\_

Max. Annual Benefit \_\_\_\_\_

Max. Annual Benefit \_\_\_\_\_

**AUTHORIZATION**

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.

\_\_\_\_\_  
Signature of patient or parent if patient is a minor

\_\_\_\_\_  
Date