

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 _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you under any medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any allergic reactions to any drug including penicillin, codeine, novocaine, and aspirin? If so what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has there been a change in your health in the past year? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever had a blood transfusion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever had abnormal bleeding problems after a cut or tooth extraction? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now taking drugs or medications? Please list them

_____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had surgery to replace a joint with a prosthesis? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you smoke or use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 Value	<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

