SAM J. HALABO, DMD
COSMETIC AND FAMILY DENTISTRY
Creating Beautiful Smiles

Welcome

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve.

Please complete this form so that we can provide the best care possible for you.

About you

Name: _____

I like to be called: _____

Social Security Number: _____

Address: _____ City: _____ Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____

Date of Birth: _____ Whom can we thank for telling you about us? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er) Spouse's Name: _____

Do you have dental insurance? ☐ Yes ☐ No If Yes, which insurance carrier? _____

Do you have flex or health spending (FSA or HSA) accounts with your employer? ☐ Yes ☐ No

Special interests or hobbies: _____

Contact Infomation

Home Phone: _____

Work Phone: _____

Mobile Phone: _____ When is the best time to call you? _____

E-mail Address: _____

Best way to contact you? (Check all that apply) E-mail _____ Text _____ Phone (Best Contact #) _____

In case of emergency, who may we call? _____

Relationship: _____ Phone: _____

Medical History

Name of personal physician: _____ Phone Number: _____

Last visit with a physician: _____ Current Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke or use chewing tobacco? ☐ Yes ☐ No If yes, How Much Per Day? _____

Are you currently taking prescription medications? ☐ Yes ☐ No If yes, please list below:

Name of Medication	Purpose	Name of Medication	Purpose

For Women: Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____

Do you plan on becoming pregnant in the near future, and when? _____

Have you had any serious medical problems within the past 5 years? ☐ Yes ☐ No If yes, please explain:

_____

_____

Medical History ... *Continued*

Please CIRCLE the appropriate response

Have you ever had, or been treated for, any of the following diseases or medical problems?

Y N Heart Attack /Stroke
Y N Hepatitis /Jaundice
Y N Epilepsy /Seizures /Fainting
Y N Cancer /Chemotherapy
Y N Psychiatric Problems
Y N Tuberculosis
Y N AIDS /HIV
Y N Heart Murmur /Rheumatic Fever
Y N High /Low Blood Pressure
Y N Abnormal Bleeding /Anemia
Y N Kidney Problems
Y N Diabetes
Y N Drug /Alcohol Abuse
Y N Osteoporosis / Fosamax

Have you been treated for any other illnesses not listed above? ☐ Yes ☐ No If yes, please explain:

_____

Do you need to be pre-medicated before dental treatment? ☐ Yes ☐ No ☐ Don't Know

Do you have a history of use of diet drugs such as phen/fen, metabolife, etc? ☐ Yes ☐ No Which One? _____

Are you allergic to any Medications, Latex or Anesthetics? ☐ Yes ☐ No If yes, please list: _____

_____

Dental History

What is the reason for today's visit? _____

_____

How would you describe the condition of your teeth and gums? ☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums? ☐ Yes ☐ No If yes, please explain:

_____

The date of your last dental visit: _____ Previous dentist`s name: _____

Are you delighted with your smile? ☐ Yes ☐ No Rate your smile from 1 to 10(1=hate smile, 10=love smile) _____

If you could wave a magic wand, and change anything you could about the appearance of your smile, what would you do? _____

_____

If there was a simple way for you to have straight teeth without braces would you be interested? ☐ Yes ☐ No

Would you like to have your Metal/Mercury fillings removed? ☐ Yes ☐ No

If you could easily and safely whiten your teeth, would you be interested? ☐ Yes ☐ No

Do you have any special occasions coming up? _____

How often do you brush your teeth per day? _____ Floss your teeth per day? _____

Are you concerned about your breath? _____

Do your gums bleed when you brush? ☐ Yes ☐ No When you floss? ☐ Yes ☐ No

Have you ever experienced pain in your jaw joint or headaches when you wake up? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No If yes, please explain: _____

I understand that the above information is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and only used to improve communication between Dr. Halabo, his associates and myself. I also give permission to Dr. Halabo and his associates, to use any photos they may take for communicating with dental laboratories, lecturing or education purposes. I authorize the release of information to my insurance carrier and also authorize payment to be made directly to Sam J. Halabo DMD Inc. Payment for all treatment is due at the time of service. As a courtesy to you we will submit claims for payments to your insurance company. We expect all insurance claims to be paid within 30 days of submission. If your insurance has not paid by then, you will be responsible for the full payment. Thank you and welcome to our office.

Signature _____ Date _____