ABBAS FAMILY DENTISTRY, INC.
GH ASCARZADEH D.M.D.
3397 HELENA RD. PO Box 617
HELENA, AL 35080
205-620-4300

Date_____

Name_____ Home#_____
Mailing
Address_____ Cell#_____

_____Date of Birth_____

City, St_____ Zip_____

E-Mail Address _____

Sex M____ F____ Marital Status S____ M____ D____ W____

Previous Address (If less than 3 years)_____

City, St _____ Zip_____

Employer_____

Employer Address_____

Job Description_____ Soc. Sec. #_____

Who may we thank for referring you to our office?_____

Who is financially responsible for this bill?_____

Nearest relative not living with you_____Phone_____

Nearest friend not living with you_____ Phone_____

Whom may we contact in case of an emergency?_____

Relationship_____ Phone_____

Spouse's name_____ Soc Sec#_____

Date of birth_____ Employer_____

Dental History

Reason for appointment today_____

Date of last dental examination_____ Why?_____

Dentist's name_____ Last dental x-rays_____

Yes No

___ ___ Have you ever had an allergic reaction to local anesthetic?
___ ___ Have you ever been treated for periodontal (gum) disease?
___ ___ Do you have missing teeth?
___ ___ Do you have sores, swelling, or blisters on your gums? Cheeks? Lips?
___ ___ Are your gums red, swollen, or tender?
___ ___ Do you see pus between your teeth and your gums when they are pressed?
___ ___ Are your permanent teeth loose or separating?
___ ___ Have you ever had any complications after dental treatment?
___ ___ Is there any change in the fit of your partial dentures?
___ ___ Do you have bad breath?
___ ___ Would you like whiter teeth?

Medical History

Date of last physical examination_____ Physician's Name_____

Are you allergic to any medications? Yes_____ No_____
If so, please list_____

Are you taking any medications? Including birth control Yes____ No_____
If so please list_____

Have you ever been treated for cancer: _____ When_____
Have you ever had a bleeding problem after oral or medical surgery? Yes____ No____

Are you pregnant? Yes___ No___ Breast feeding? Yes___ No____

Please check if you have, or have ever had any of the following

___ Rheumatic Fever	___ Diabetes	___ Kidney Problems
___ Rheumatic Heart Disease	___ Thyroid	___ Kidney Dialysis
___ Mitral Valve Prolapse	___ Seizures	___ Joint pain
___ Congenital Heart Disease	___ Stroke	___ Headaches
___ Chest pain	___ Liver Disease	___ Anemia
___ Angina	___ Hepatitis	___ HIV (AIDS)
___ Heart Attack	___ Asthma	___ Venereal Disease
___ Heart Surgery	___ Breathing Problems	___ Lung Problems
___ High Blood Pressure	___ Joint Replacement	___ Head Injury

Is there anything not listed above that we should be aware of?_____

Insurance Information

Primary Insurance

Insured's Name_____ Soc Sec # _____

Employer_____ Group#_____

Insurance Company Name_____
Insurance Company Address_____

Secondary Insurance

Insured's Name_____ Soc Sec#_____

Employer_____ Group#_____

Insurance Company Name_____
Insurance Company Address_____

Medicaid Number_____

I, hereby give Dr. GH Ascarzadeh and staff my consent to perform whatever dental procedures they deem necessary or advisable. I agree to the use of local anesthetic or a nitrous oxide and oxygen analgesic, depending on the judgment of the dentist and myself.
In the event of any dental emergency, I agree to allow the necessary treatment be administered by any of the dentists currently on the dental staff.
I give consent for appointment reminder cards to be mailed, and for work/school excuses to be given or faxed for myself or for a minor child.
When treatment plans are presented, the expected insurance payment is an estimate only. If for any reason the insurance company does not pay the estimated amount, I will be responsible for the bill.
I/We, in order to set up an account at this office, give permission to Dr. Ascarzadeh to review my credit. All accounts are charged 1.5% per month interest (18% per year) and $10.00 per month statement fee 60 days from the treatment date.
I also agree to pay any costs of collection should this account become delinquent and reasonable attorney's fees and hereby waive my rights of exemption under the laws of the state of Alabama and any other state.

Signature_____ Date_____