Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

PATIENT REGISTRATION

WELCOME - The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

ABOUT YOU

Email Adress:
Last Name:
First Name: MI:
I prefer to be called:
Gender: ☐ Male ☐ Female ☐ Other
Preferred Pronoun:
Birthdate: Age:
Address: Apt #:
City: State: ZIP:
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated ☐ Partnered
Hm #: Cell #:
Wk #: Ext:
Preferred Contact Method: ☐ Home Phone ☐ Work Phone
☐ Wireless Phone ☐ Email ☐ Text Message

Employer:
Occupation:
Whom may we thank for referring you?
Other family members seen by us:
☐ Previous / ☐ Present Dentist:
(please check)
Person Responsible for Account:

EMERGENCY CONTACT

Relative or Friend not living with you

His/Her Name:
Relation: Phone #:

INSURANCE COVERAGE

PRIMARY

Dental Coverage? ☐ Yes ☐ No
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group Name:
Group # (Plan, Local or Policy #):
Insured's Name:
What is your relationship to the Insured?
☐ Self ☐ Spouse ☐ Significant Other ☐ Child
Insured's Birthdate:
Insured's ID #:
Insured's Employer:
Employer's Address:

SECONDARY

Dental Coverage? ☐ Yes ☐ No
Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group Name:
Group # (Plan, Local or Policy #):
Insured's Name:
What is your relationship to the Insured?
☐ Self ☐ Spouse ☐ Significant Other ☐ Child
Insured's Birthdate:
Insured's ID #:
Insured's Employer:
Employer's Address:

Signature

Today's Date:

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name:

Relationship:

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

HEALTH HISTORY

PATIENT _____ _____ _____
LAST NAME FIRST NAME BIRTHDATE

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter drugs? ☐ Yes ☐ No

Please list each one in the spaces below:
(For patients updating in-office: Mark any medications that you are no longer taking and add any new ones.)

☐ _____ ☐ _____
☐ _____ ☐ _____
☐ _____ ☐ _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

(Also known as Redux or Pondimin) If so, when? _____

FOR WOMEN: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N		Y	N	
☐	☐	Abnormal Bleeding/Hemophilia	☐	☐	Herpes/Fever Blisters
☐	☐	AIDS	☐	☐	High Blood Pressure
☐	☐	Alcohol/Drug Abuse	☐	☐	HIV
☐	☐	Anemia	☐	☐	Hospitalized for Any Reason
☐	☐	Arthritis	☐	☐	Kidney Problems
☐	☐	Artificial Bones/Joints/Valves	☐	☐	Liver Disease
☐	☐	Asthma	☐	☐	Low Blood Pressure
☐	☐	Blood Transfusion	☐	☐	Lupus
☐	☐	Cancer/Chemotherapy	☐	☐	Mitral Valve Prolapse
☐	☐	Colitis	☐	☐	Pacemaker
☐	☐	Congenital Heart Defect	☐	☐	Psychiatric Treatment
☐	☐	Diabetes	☐	☐	Radiation Treatment
☐	☐	Difficulty Breathing	☐	☐	Rheumatic/Scarlet Fever
☐	☐	Emphysema	☐	☐	Seizures
☐	☐	Epilepsy	☐	☐	Shingles
☐	☐	Fainting Spells	☐	☐	Sickle Cell Disease/Traits
☐	☐	Frequent Headaches	☐	☐	Sinus Problems
☐	☐	Glaucoma	☐	☐	Stroke
☐	☐	Hay Fever	☐	☐	Thyroid Problems
☐	☐	Heart Attack/Surgery	☐	☐	Tuberculosis (TB)
☐	☐	Heart Murmur	☐	☐	Ulcers
☐	☐	Hepatitis	☐	☐	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Penicillin
☐	☐	Dental Anesthetics	☐	☐	Tetracycline
☐	☐	Erythromycin	☐	☐	Other
☐	☐	Jewelry/Metals			

Please list any other drugs/materials that you are allergic to:

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Type of bristles on your toothbrush? ☐ Soft ☐ Medium ☐ Hard

Have you ever had gum treatment? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No Itch? ☐ Yes ☐ No

Have you ever had periodontal disease? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ TMD)? ☐ Yes ☐ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? ☐ Yes ☐ No

Do you still have wisdom teeth? ☐ Yes ☐ No

Do you have dry mouth? ☐ Yes ☐ No

Have you chipped or fractured any teeth? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change?

_____

Patient/Guardian Signature Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Consent Form

Last Name: _____ First Name: _____ Birthdate: _____

We are honored that you have selected us to provide dental care for you.

I, _____ give consent for myself/my child to receive dental treatment deemed necessary by the doctors and staff at Ghina Morad, DMD. These procedures include, but are not limited to; examinations, x-rays, oral prophylaxes, fluoride treatments, sealants, restorations such as composite fillings and crowns, periodontal treatments, endodontic (root canal) treatments, extractions,orthodontic treatments, and the use of local anesthetics. This consent shall be considered in effect until rescinded or revoked.

Changes in Treatment Plan:

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Risk of Dental Procedures:

May Include but are not limited to, complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, Thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular jaw (TMJ) joint difficulty and injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Medication and drugs may cause drowsiness (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Release of Photos:

I understand the use of photos, videos, or other images taken may be used by Ghina Morad, DMD, using my name or a fictitious name in media form. I release any and all claims whatsoever in connection with the use of my photography, name and reproduction of material.

For children under the age of 18:

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize the release of information for my child to these parties:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Comments: _____

By signing this Consent Form, I have read, understand and agree to the terms and conditions.

Signature

Today's Date: _____

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Financial Agreement

Last Name: _____ First Name: _____ Birthdate: _____

Thank you for choosing us as your dental care provider. We are committed to providing you with the best experience possible. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

PAYMENT:

The patient's portion (whatever the insurance is not expected to cover) is due at the time of service unless other payment arrangements have been made with the Financial Manager. For more extensive treatments, financing options are available and multiple options will be offered to help you complete your treatment in full. In the event payment is not received on the agreed upon date, a finance charge will be applied. If the insurance pays more than we estimated, the excess will be refunded to you.

INSURANCE:

You should be aware that Insurance companies base their coverage on a fixed fee schedule that may not coincide with our fees. Furthermore, they might change their restrictions without any previous notice to us or to you.

Our staff will gladly try to determine your insurance coverage to the best of their ability and prepare all the forms to bill your insurance for you as a courtesy on your behalf. After 60 days of being billed, if your insurance has not paid, the insurance balance will become your responsibility.

Additionally, should your insurance benefits result in less coverage than anticipated, you are still fully responsible for the full fee of the treatment.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation two business days prior to scheduled treatment, you will be charged the cancellation fee. Please help us service you better by keeping scheduled appointments and be aware that by failing to attend your appointment, you are taking the time from another patient who possibly needed that time.

By signing this Financial Agreement, I have read, understood, and have agreed to all these terms and conditions.

_____ Today's Date: _____

Signature

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Notice of Privacy Policies

Last Name: First Name: Birthdate:

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for nonhealthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- In situations required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means or location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Notice of Privacy Policies

- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

* Conditions and limitations may apply; obtain additional information from front desk.

As my Dental Care provider, I give my permission to contact me or leave a confidential voicemail for myself on my:

☐ Home phone ☐ Cell phone ☐ Work phone

I give my permission to contact me or leave a confidential message for myself via email.

☐ Yes ☐ No

Signature

Today's Date: _____

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____

Ghina Morad, DMD
Beautiful Faces, Radiant Smiles

Dental Material Fact Sheet Acknowledgement

Last Name: _____ First Name: _____ Birthdate: _____

As of January 1, 2002, the Dental Board of California requires that we distribute to our patients a copy of The Dental Material Fact Sheet. This is available from our front desk staff upon your request. Please sign below acknowledging your right to review this information.

_____

Signature

Today's Date: _____

If signed by a personal representative of the patient, describe the representative's relationship to and authority to act for patient.

Representative's Name: _____

Relationship: _____