PATIENT INFORMATION

DATE: _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK

_____
CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURANCE

PRIMARY INSURED OR RESPONSIBLE PARTY	SECONDARY INSURED
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK	HOME WORK
CELL E-MAIL	CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO.	EMPLOYER DENTAL INS. CO.
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

PERSONAL CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/Zip _____

Telephone # _____

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or health professionals.

X _____ _____ _____
Patient or responsible party Date State Driver's License #

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I understand that if I decline to undergo treatment, delay treatment, or fail to keep my appointment (s), I accept that there may be permanent irreversible damage to my dental health.

   _____ Please initial

4. I agree to the use anesthetics, sedatives and other medication, as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent/Responsible Party's Signature _____ Relationship to Patient _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Signature: _____ Date: _____

Dependent family members also covered by this acknowledgement: _____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Dr. Ban Barbat, DDS - PC

Where Lasting Smiles Begin

MEDICAL HISTORY

Patient Name

1. Have you been under the care of a medical doctor during the past two years? ..... Yes No

   If yes, for what? _____

   Physician's Name _____ Phone _____

   Address _____ City _____ State _____ Zip ____

2. List all medications, drugs, supplements, vitamins or pills you are currently taking or circle "none" if you are taking none. None

   Please list name and dosage _____

   _____

   (ask for an additional page if you need more room)

3. Are you aware of having an **allergic or adverse reaction** to any medication or substance? ..... Yes No

   If yes, please list: _____

4. Indicate which of the following you have had, or have at present. **Circle "yes" or "no" to each item.**

A.I.D.S	Yes No	Contact Lenses	Yes No	Nervous/Anxious	Yes No
Allergies or Hives	Yes No	Cortisone Medicine	Yes No	Neurological Disorders	Yes No
Allergy to Codeine	Yes No	Diabetic	Yes No	Pacemaker	Yes No
Allergy to Demerol	Yes No	Diet (Special/Restricted)	Yes No	Psychiatric/Psychological Care	Yes No
Allergy to Latex	Yes No	Emphysema	Yes No	Radiation Therapy	Yes No
Allergy to Penicillin	Yes No	Epilepsy or Seizures	Yes No	Respiratory Disease	Yes No
Allergy to Sulfa	Yes No	Fainting Spells	Yes No	Rheumatic Fever	Yes No
Allergy to topical anesthesia	Yes No	General Allergies	Yes No	Rods, Pins, Plates	Yes No
Arthritis/Rheumatism	Yes No	Glaucoma	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Hay Fever	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Heart Murmur	Yes No	Sleep Apnea	Yes No
Asthma	Yes No	Heart Problems	Yes No	Stent	Yes No
Blood Transfusion	Yes No	Hemophilia	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Hepatitis	Yes No	Swollen Ankles	Yes No
Bypass surgery	Yes No	Herpes	Yes No	Takes Coumadin	Yes No
Cancer or Tumor	Yes No	High Blood Pressure	Yes No	Thyroid Problems	Yes No
Chemotherapy	Yes No	HIV	Yes No	Tuberculosis	Yes No
Chest Pain	Yes No	Kidney Trouble	Yes No	Ulcers	Yes No
Chronic Cough	Yes No	Latex Sensitivity/Allergy	Yes No	Venereal Disease	Yes No
Cold Sores/Fever Blisters	Yes No	Liver Disease	Yes No	Wear CPAP or VPAP	Yes No
Congenital Heart Disease	Yes No	Mitral Valve Prolapse	Yes No	Yellow Jaundice	Yes No

5. Have you experienced or are you experiencing dry mouth..... Yes No

6. Do you have or have you had any **disease, condition, or problem** not listed?..... Yes No

7. **Women.** Are you: **Pregnant? / Trying to get Pregnant?** Yes, _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed. you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ **Date** _____

History Review

Dentist Signature _____ Date _____

DENTAL HISTORY

DENTAL HEALTH and APPEARANCE

Are you having any problems or complaints at this time? Yes ☐ No ☐
If so, please describe in detail _____

_____

_____

Reason for visit: _____ Approximate date of last dental visit: _____

What is your primary concern that you would like us to address first? _____

Have you ever had any serious problem associated with previous dental treatment?.....Yes ☐ No ☐

If so, explain: _____

What, if anything, has happened in previous experiences at the dentist, that was reason not to return?_____

_____

Do you have missing teeth? _____ If yes, have you had them replaced? _____

If not, would you like to learn about your options to replace them?_____

How often do you brush your teeth? _____ How often do you floss (routinely)? _____

Do you avoid brushing any part of your mouth because of pain?.....Yes ☐ No ☐ If yes please describe?_____

_____

_____

Which foods cause you twinges of pain: Hot ☐ Cold ☐ Sweet ☐ Sour ☐ None ☐

Do you lose fillings or break fillings?.....Yes ☐ No ☐

Do you chew on only one side of your mouth? .....Yes ☐ No ☐ If yes, explain _____

Do your gums feel tender or swollen?.....Yes ☐ No ☐

Do you usually have many cavities?.....Yes ☐ No ☐

Do you clench or grind your jaws while sleeping or during the day.....Yes ☐ No ☐

Do your jaws ever feel tired?.....Yes ☐ No ☐

TMJ SCREENING

Do you experience problems opening or closing your jaw? .....Yes ☐ No ☐

Are your jaw muscles sore in the morning or evening?.....Yes ☐ No ☐

Please circle one or both.....Morning Evening

Do you experience pain in your jaw or jaw muscles during chewing? .....Yes ☐ No ☐

Does or has your jaw ever locked?.....Yes ☐ No ☐

Are you aware of a habit of clenching or grinding currently or in the past?.....Yes ☐ No ☐

Please circle one or both.....Clenching Grinding

COSMETIC/ESTHETIC EVALUATION

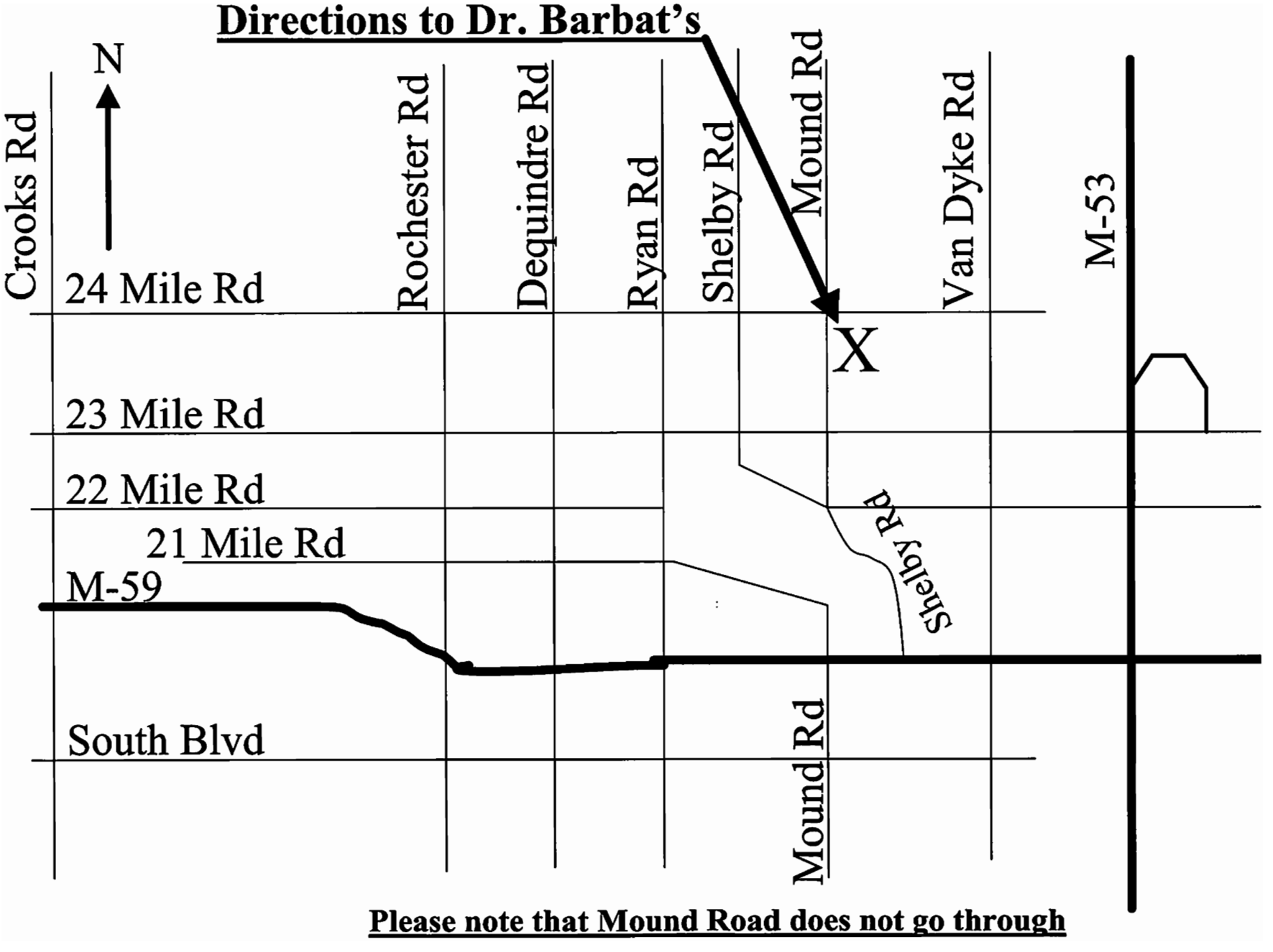
Are you delighted with your smile? _____ Please *rate* from 1 to 10 (1= I hate my smile, 10=awesome) _____

Would you like to have whiter teeth?.....Yes No

If you had a *magic* wand what, if anything, would you change about your smile? _____

_____

_____


Directions to Dr. Barbat's
N
Crooks Rd
Rochester Rd
Dequindre Rd
Ryan Rd
Shelby Rd
Mound Rd
Van Dyke Rd
M-53
24 Mile Rd
X
23 Mile Rd
22 Mile Rd
21 Mile Rd
M-59
Shelby Rd
South Blvd
Mound Rd
Please note that Mound Road does not go through