PREMIER FAMILY DENTAL
STRONGSVILLE. WESTLAKE.

Welcome to our Office!

Date:_____

PATIENT INFORMATION:

Name:_____Birth Date:_____

Social Security#_____

Address:_____

City:_____Zip_____

EMPLOYMENT INFORMATION:

Employer Name_____Phone_____

Whom may we thank for referring you?_____

PATIENT CONTACT INFORMATION:

Home Phone:_____Cell Phone:_____

E-mail address_____

Where do you prefer to be contacted: ( ) Home ( ) Work ( ) Cell ( )E-mail

Emergency Contact:_____Relationship to patient_____

Contact Phone:_____Contact Alternate Phone_____

Responsible Party for this account (if other than Patient)_____

Responsible Party Address & Phone (if different from Patient)_____

INSURANCE INFORMATION:

Insurance Plan Name/Address/Phone_____

Insurance ID#_____Group #_____

Complete the following for the Policy Holder (if Different from Patient or Responsible Party)

Name;_____Birth Date:_____Relationship to Patient_____

Address:_____City_____

Zip_____Phone:_____

PLEASE SEE REVERSE SIDE PAGE (OVER)

MEDICAL INFORMATION

Patient Name:_____Birth Date:_____Today's Date_____

The following information is important for us to help treat your Dental needs. We appreciate your cooperation in completing this information.

Have you ever had any of the following?

( ) AIDS/ HIV	( ) Heart Disease	( ) Rheumatic Fever
( ) Allergies	( ) Heart Murmur	( ) Parkinson's Disease
( ) ADHD/ADD	( ) Hearing Difficulties	( ) Sinus Problems
( ) Anemia	( ) Hepatitis	( ) Stomach Problems (GERD)
( ) Head Injuries	( ) High Blood Pressure	( ) Stroke
( ) Artificial Joints	( ) Jaundice	( ) Sulfa Allergy
( ) Asthma	( ) Kidney Disease	( ) Thyroid Problems
( ) Fibromyalgia	( ) Latex Allergy	( ) Tuberculosis
( ) Respiratory Problems	( ) Liver Disease	( ) Tumors/Growths
( ) Diabetes	( ) Lymes Disease	( ) Mouth Ulcers
( ) Dizziness	( ) Alzheimer's /Dementia	( ) Venereal Disease/STD
( ) Epilepsy/Seizures	( ) Mitral Valve Prolapse	( ) Codeine Allergy
( )Excessive Bleeding	( ) MS	( ) Sleep Apnea
( ) Fainting	( ) Panic Attacks	( ) Tobacco Use
( ) Glaucoma	( ) Pacemaker	( ) Drug/Alcohol Abuse
( ) Penicillin Allergy	( ) Radiation Treatment	( )Depression
( ) Arthritis: ( ) Degenerative ( ) Rheumatoid	( ) Cancer: Type:_____	( ) Are you pregnant? Due Date:_____

Medications

*What medications are you taking, including "over the counter", ie Aspirin, vitamins, etc?_____

*What prescription medications are you currently taking?_____

_____

***Are you allergic to any of the following**? (Please Circle)

Aspirin, Barbiturates, Codeine, Dental Anesthetics, Erythromycin, Jewelry/Metals, Latex, Penicillin, Sedatives, Sulfa Drugs, Tetracycline

*Do you have any other **Allergies to Medications**? ( ) Yes ( ) No If Yes, What medications are you allergic to?_____

General Health Questions

***Have you been admitted to a hospital or needed emergency care during the past two years ( )No. If yes, please explain:_____

_____

*Are you under the care of a Physician ( )Yes ( )No If yes, please explain:_____

_____

*Do you have any Health Concerns: (Please Explain)_____

_____

Name of Physician Phone:

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need.

Signature of Patient/Parent/Legal Guardian_____date_____

Welcome! We look forward to helping you achieve the smile you want.
The following questions will help us get started……

Patient Name:_____Date:_____

1. Date of last teeth cleaning_____
2. Date of last Full Mouth x-ray Series _____
3. Have you ever had a cosmetic consultation?_____
4. Have you used any whitening products, either professional or over the counter products?_____if so which_____

   _____
5. Check any of the following social habits that apply:
   ( )Coffee ( )Tea ( )Soda ( )Red Wines ( )Smoking ( )Bite Nails
   ( )Teeth Grinding ( )Other_____
6. What do you want to change about your smile?_____

   _____

   _____
7. What do you NOT want to change about your smile?_____

   _____
8. If needed, would you consider Orthodontics (braces) as a treatment option?_____
9. Check any of the following that apply: I feel my teeth are:

   ( )Dark ( )Small ( )Long ( )Pointed ( )Rotated ( )Spaced ( )Chipped ( )Discolored

   ( )Decayed ( )Stained
10. I am mostly interested in information about:_____

    _____

    _____

    _____

*Is your water fluoridated ( ) Yes ( ) No
* Do you take fluoride vitamin/supplements? ( ) Yes ( ) No
*Have you ever been treated for gum/periodontal disease? ( ) Yes ( ) No

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* **(HIPPA**). I understand 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 below 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 of health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

_____

Print Patient's Name Date

_____

Signature of Patient/Legal Guardian

Dependant family members also covered by this acknowledgment_____

_____

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons: ( ) Patient refused to sign ( )Communication Barriers ( )Emergency Situation ( )Other.

_____

CONSENT FOR DENTAL PROCEDURES

1. I hereby authorize NJK Premier Family Dental, Inc., Premier Family Dental Westlake, Koussa DDS, Inc. and Dr. Nadeem J. Koussa, Dr. Natalie Nechvatal, hereafter known as Premier Family Dental, and it's employees, agents and assistants to perform all dental procedures or course of procedures necessary to diagnose, treat and care for the patient's dental needs. If any unforeseen condition arises during the course of the procedure, I request and authorize the aforementioned Dentist, Premier Family Dental, and it's employees, agents and assistants to perform and do whatever is clinically necessary to treat such unforeseen condition(s).
2. The purposes of these dental procedures or course of procedures are to diagnose and treat the patient's dental problem
3. These dental procedures are expected to provide for the restoration and maintenance of good oral health. However, I acknowledge and understand that those dental procedures or course of procedures do not always produce desired, expected or successful results and that NO GUARANTEES can be or have been made concerning the results of these procedures.
4. The reasonably known risk of these dental procedures or course of procedures are: allergies that may occur with the use of any medication.
5. I acknowledge that full and complete disclosure of the information in this consent form has been made and that all my questions asked about these procedures have been answered in a satisfactory manner.

_____

Print Patient's Name

_____

Signature of Patient/Parent/Legal Guardian Witness Date