saad ORAL HEALTH & BEAUTY

WELCOME!

Thank you for choosing Saad Dental Group to help care for your oral health. We all look forward to getting to know you better.

In order for us to evaluate and treat you with the most optimal care, it is very important for you to retrieve your most recent records (including all x-rays) from your previous dentist prior to your appointment with us.

To make this process easier, please provide us with your previous dentist's contact information and we will request the records on your behalf (after the transfer papers are signed.) If you do not have access to your prior records, we will need to take the necessary x-rays in order to do a comprehensive examination. You will be responsible for the cost of the x-rays if your insurance company will not pay for them.

Please review the remaining items in this packet, fill out the paperwork, and return them during your first visit.

It is our pleasure to welcome you as a new patient to our practice. If you have any questions or concerns, feel free to call us any time.

Ali Y. Saad, DMD
Mohamed Y. Saad, DDS
Roua Al-Rawi, DDS
Linda Murad-Ajluni, DDS

837 Forest Avenue
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248 646-3515 office
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PATIENT HEALTH AND HISTORY

INFORMATION ABOUT YOU

Name: _____ Home Phone #: _____

Address: _____ Cell Phone #: _____
street

_____ Social Security #: _____
city state zip code

Birthdate: _____ Sex: _____ Marital Status: _____

Employer: _____ Work Phone #: _____

Employer's Address: _____ E-mail address: _____
street

_____ Who may we thank for referring you: _____
city state zip code

SPOUSE INFORMATION

Spouse's Name: _____ Spouse's Employer: _____

NEIGHBOR OR RELATIVE NOT LIVING WITH YOU

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

PERSON RESPONSIBLE FOR ACCOUNT OTHER THAN YOURSELF

Name: _____ Social Security #: _____

Address: _____ Relationship: _____

Home Phone #: _____ Cell Phone #: _____

Driver's License #: _____ Work Phone #: _____

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Insurance Co Phone #: _____

Insured's Name: _____ Relationship: _____

Insured's Soc. Sec. #: _____ Group/ID #: _____

Insured's Birthdate: Insured's Employer:

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Co. Name: _____ Insurance Co Phone #: _____

Insured's Name: _____ Relationship: _____

Insured's Soc. Sec. #: _____ Group/ID #: _____

Insured's Birthdate: Insured's Employer:

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PATIENT HEALTH AND HISTORY

DENTAL HISTORY

Do you require antibiotics (PRE-MED) before dental treatment?: _____ Have you ever had gum disease?: _____
Do you now (or have ever) experienced pain/discomfort in your jaw joint TMJ/TMD?: _____ Do your gums ever bleed?: _____
Previous / Present Dentist: _____ Last Visit Date: _____
(circle one)

MEDICAL HISTORY

Your physician's name: _____ Physician's phone #: _____
Do you take a blood thinner or blood pressure medications?: _____
Your current medications: _____
Are you taking them as directed?: _____ If *No,* please explain: _____
Are you taking any non-prescription or herbal medications or supplements?: _____

Are you allergic to any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
____	____	Aspirin (AA)	____	____	Dental Anesthethics (DE)	____	____	Latex (LA)	____	____	Sulfa Drugs (SU)
____	____	Barbiturates (BA)	____	____	Erythromycin (EY)	____	____	Penicillin (AP)	____	____	Tetracycline (TE)
____	____	Codeine (AC)	____	____	Jewelry/Metals (JM)	____	____	Sedatives (SP)	____	____	Iodine (IO)

List any additional drugs / materials that cause allergic reactions: _____

Have you ever had:

Yes	No		Yes	No		Yes	No	
____	____	Abnormal Bleeding (AB)	____	____	Eating Disorders (ED)	____	____	Nervous Problems (NE)
____	____	Acid Reflux (AF)	____	____	Epilepsy (EP)	____	____	Oral Surgery (OS)
____	____	AIDS / HIV (A)	____	____	Fainting Spells (FA)	____	____	Pacemaker (PA)
____	____	Alcohol Addiction (AU)	____	____	Freq.Headaches / Migraine (HC)	____	____	Periodontal Surgery (PR)
____	____	Arthritis (AR)	____	____	Heart Attack (HA)	____	____	Prosthetic Joints (PJ)
____	____	Artificial Heart Valves (AH)	____	____	Heart Murmur (HM)	____	____	Radiation Treatments / Chemo (CM)
____	____	Asthma (AS)	____	____	Heart Surgery (HS)	____	____	Rheumatic Fever (RH)
____	____	Blood Disease (BD)	____	____	Hemophilia (HO)	____	____	Scarlet Fever (SF)
____	____	Blood Transfusions (BT)	____	____	Hepatitis (*date*_____)	____	____	Sinus Problems (SI)
____	____	Cancer (CA)	____	____	High Blood Pressure (HB)	____	____	Smoke or Use Tobacco (SM)
____	____	Chest Pains (CP)	____	____	Implants (any type)	____	____	Stroke (ST)
____	____	Circulatory Problems (CR)	____	____	Kidney Disorders (KT)	____	____	Thyroid Problem (TH) (TL)
____	____	Complication from Dental Surgery (CD)	____	____	Liver Disease (LD)	____	____	Tuberculosis (TB)
____	____	Convulsions or Seizures (SE)	____	____	Low Blood Pressure (LB)	____	____	Ulcers (UL)
____	____	Diabetes (DI)	____	____	Mitral Valve Prolapse (MP)	____	____	Venereal Disease (VD)
____	____	Drug Abuse (DA)						

Please explain any hospitalizations, surgeries or serious medical condition: _____

For women:
Are you taking birth control pills? Are you pregnant? Week # Are you nursing?

I affirm that the information I have given is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. I understand that I am responsible for payment of all services rendered, but as a service to me, this office will submit dental claims. I assign to Saad Dental Group, all insurance benefits, otherwise payable to me. I authorize them to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature (Patient/Legal Guardian): _____
Date: _____

Payment is due at time of service:
Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

MEDICAL HISTORY UPDATE

B/P	Pulse	Date	Staff

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CHILD HEALTH HISTORY

CHILD'S NAME: _____

DATE OF LAST DENTAL EXAM: _____

HAS THERE BEEN ANY PROBLEM IN YOUR CHILD'S GENERAL HEALTH?: _____

IS HE/SHE UNDER A PHYSICIAN'S CARE?: YES NO TAKING ANY MEDICATION?: _____

IF SO, FOR WHAT REASON?: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING PROBLEMS?

	YES	NO		YES	NO
RHEUMATIC FEVER	____	____	PROLONGED BLEEDING	____	____
HEART MURMUR	____	____	ASTHMA	____	____
HEART TROUBLE	____	____	HAY FEVER	____	____
HIGH BLOOD PRESSURE	____	____	CONVULSIONS	____	____
DIABETES	____	____	EPILEPSY	____	____
BLOOD DISORDERS	____	____	HEPATITIS	____	____
LIVER DISORDERS	____	____	FAINTING	____	____
KIDNEY DISORDERS	____	____	CANCER	____	____
ANEMIA	____	____			
OTHER	____	____	EXPLAIN: _____		

ALLERGIC TO OR HAD ANY UNUSUAL REACTIONS TO THE FOLLOWING?

ASPIRIN	____	____	BARBITURATES	____	____
CODEINE	____	____	DENTAL ANESTHETIC	____	____
PENICILLIN	____	____	ANTIBIOTICS	____	____
OTHER	____	____	IF SO, WHAT: _____		

DOES HE/SHE GET HEADACHES OFTEN?: _____

PHYSICIAN'S NAME: _____ ADDRESS: _____

PHYSICIAN'S PHONE #: _____

NOTE: PLEASE INFORM A MEMBER OF OUR STAFF OF ANY CHANGES IN YOUR CHILD'S MEDICAL STATUS PRIOR TO THE START OF ANY DENTAL PROCEDURE.

Signature (Patient/Legal Guardian): _____ **Date:** _____

CONTINUES ON OTHER SIDE

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CHILD HEALTH HISTORY

Adolescent Patient Registration:

NAME OF CHILD: _____ DATE: _____

ADDRESS: _____ AGE: _____

CITY: _____ DATE OF BIRTH: _____

SCHOOL: _____ HOME PHONE: _____

CELL PHONE: _____

FATHER'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____

EMPLOYED BY: _____ BUS. PHONE: _____

DOES FATHER HAVE DENTAL INSURANCE?: _____ NAME OF INSURANCE CO.: _____

FATHER'S DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

MOTHER'S NAME: _____ HOME PHONE: _____

CELL PHONE: _____

EMPLOYED BY: _____ BUS. PHONE: _____

DOES MOTHER HAVE DENTAL INSURANCE?: _____ NAME OF INSURANCE CO.: _____

MOTHER'S DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

PARENTS MARITAL STATUS: _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

I WAS REFERRED TO THIS OFFICE BY: _____

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NOTICE OF PRIVACY PRACTICES, PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

➔ The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
➔ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
➔ The right to receive confidential communications of protected health information.
➔ The right to inspect and copy protected health information.
➔ The right to amend protected health information.
➔ The right to receive an accounting of disclosures of protected health information.
➔ The right to obtain a paper copy of this practice’s Notice of Privacy Practices upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practices's current Notice of Privacy Practices on request.

Signature (Patient/Legal Guardian): _____

Date: _____

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CONSENT TO DENTAL PHOTOGRAPHY

I, _____ (Patient), authorize Saad Dental Group, to take photographs, and/or videos of my face, jaws, and teeth, before, during, and after treatment.

I consent to allow the photographs to be used for the following:

- Dental Records
- Dental Research
- Dental Education including lectures, seminars, demonstrations, and professional publications such as journals or books
- Marketing material, including websites, printed materials, and patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

____ Check here if you **do not** want your full face shot used for any of the above purposes.

Signature (Patient/Legal Guardian): _____

Date: _____

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