Akram E. Rafla, D.M.D., P.C.
Practice Limited To
Periodontics With Services in Implants/Oral Medicine
WWW.AKRAMRAFLA.COM

PATIENT INFORMATION

Name: _____ **Date:** _____ **Sex: M or F**
Last *First* *M.I.*

Birthdate: ____/____/____ **SSN:** ____ - ____ - ____ **Please Circle:** Single / Married / Divorced / Widowed

Address: _____
Street *City* *State* *Zip*

Home Phone: (____) ____ - ____ **Work Phone:** (____) ____ - ____ **Cell:** (____) ____ - ____

Email Address: _____ **Would you like to receive updates via email?** ❑ **Yes or** ❑ **No**

Occupation: _____ **Employer:** _____

Spouse's Name: _____ **Spouse's Work Phone:** (____) ____ - ____

Emergency Contact: _____ **Relationship:** _____ **Phone Number:** (____) ____ - ____

Who is your General Dentist? _____ **Whom may we thank for referring you?** _____

HEALTH HISTORY

Physician: _____ Date of Last Visit: _____
Address: _____ Phone Number: (____) ____ - ____

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Cardiovascular

Angina	❑ Yes	❑ No
Arteriosclerosis	❑ Yes	❑ No
Atrial Fibrillation	❑ Yes	❑ No
Circulation Problems	❑ Yes	❑ No
Heart Attack: Date: _____	❑ Yes	❑ No
Heart Defect	❑ Yes	❑ No
Heart Murmur/Leaky Valve	❑ Yes	❑ No
High or Low Blood Pressure	❑ Yes	❑ No
Mitral Valve Prolapse/MVP	❑ Yes	❑ No
Pacemaker/Defibrillator	❑ Yes	❑ No
Rheumatic or Scarlet Fever	❑ Yes	❑ No
Stroke: Date: _____	❑ Yes	❑ No
Swelling of Feet or Ankles	❑ Yes	❑ No
Valve Replacement	❑ Yes	❑ No

Circulatory / Hematological

Abnormal Bleeding	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Leukemia/Lymphoma	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No

Neurological

Dizziness, Fainting	❑ Yes	❑ No
Epilepsy / Seizure	❑ Yes	❑ No
Headaches	❑ Yes	❑ No
Psychiatric Care	❑ Yes	❑ No
Vision / Hearing Impaired	❑ Yes	❑ No

Respiratory

Asthma	❑ Yes	❑ No
Cough, Persistent or Bloody	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No
Shortness of breath	❑ Yes	❑ No
Sinus Infection	❑ Yes	❑ No

Infectious Diseases

HIV / AIDS	❑ Yes	❑ No
Swollen Glands - neck	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Herpes	❑ Yes	❑ No

Endocrinologist

Diabetes: Type: _____	❑ Yes	❑ No
Thyroid: _____	❑ Yes	❑ No

Musculoskeletal

Arthritis / Rheumatism	❑ Yes	❑ No
Cortisone / Steroid Treatment	❑ Yes	❑ No
Joint Replacement (knee, hip, etc.)	❑ Yes	❑ No

Gastrointestinal

Diarrhea, persistent	❑ Yes	❑ No
Digestive Disorder	❑ Yes	❑ No
Hiatal Hernia	❑ Yes	❑ No
Liver Disease	❑ Yes	❑ No
Hepatitis, Type: _____	❑ Yes	❑ No
Ulcer / Hyperactivity	❑ Yes	❑ No

Other

Autoimmune / Immune Problem	❑ Yes	❑ No
Cancer: Type: _____	❑ Yes	❑ No
Kidney Disease	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No
Weight Loss, Unexplained	❑ Yes	❑ No
Birth Control Pills	❑ Yes	❑ No
Nursing? _____	❑ Yes	❑ No
Pregnant Due: _____	❑ Yes	❑ No

Have you been told you need to PREMEDICATE or take antibiotics prior to a dental procedure? ❑ **YES or** ❑ **NO**
Which antibiotic do you take? **For what condition?**

Please list any other medical concerns/ conditions we should know about:

MEDICATIONS
List all medications you are currently taking

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES
Check YES if you are allergic to:

Aspirin	❑ Yes	❑ No
Codeine / Other Narcotics	❑ Yes	❑ No
Iodine	❑ Yes	❑ No
Latex	❑ Yes	❑ No
Penicillin	❑ Yes	❑ No
Sulfa	❑ Yes	❑ No
Other Antibiotics _____	❑ Yes	❑ No
Other: _____	❑ Yes	❑ No

SURGERY
List ALL past surgery, major and minor:

_____
_____
_____
_____

Do you use Tobacco? ❑ **NO** ❑**YES**
How often?
(Circle all applicable) Cigarettes Cigars Pipe Chew/Dip

I certify that I have read and understand the above. I have received a copy of Akram E. Rafla, DMD P.C. Notice of Privacy Practices. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of Patient **Date** **Reviewing Doctor** **Date**

PLEASE COMPLETE THE OTHER SIDE OF FORM IF YOU HAVE DENTAL INSURANCE *

RESPONSIBLE PARTY INFORMATION

Responsible Party:_____ Relationship to Patient: _____

Address:_____

Phone: (_____) _____ - _____ Birthdate: _____/ _____ / _____

_____

Signature of Responsible Party *Date*

DENTAL INSURANCE INFORMATION

Name of Insured:_____ Relationship to Patient: _____

Insured's Birthdate: _____ / _____ / _____ SSN#: _____ - _____ - _____ Work Phone: (_____) _____ - _____

Employer:_____

Name *Address*

Insurance Company: _____ Group #: _____ ID#: _____

Ins. Co. Address: _____

City *State* *Zip Code*

Do you have additional Insurance? ❑ YES ❑ NO If yes, please complete the following:

Name of Insured:_____ Relationship to Patient: _____

Insured's Birthdate: _____ / _____ / _____ SSN#: _____ - _____ - _____ Work Phone: (_____) _____ - _____

Employer:_____

Name *Address*

Insurance Company: _____ Group #: _____ ID#: _____

Ins. Co. Address: _____

City *State* *Zip Code*

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. Akram E. Rafla, D.M.D., P.C., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature *Date*