Welcome to Bel Air Dental Care

Alan R. Scharf, DDS/FAGD **Gregory G. Indyke, DMD** **Anthony H. Hamod, DDS**

Thank you for selecting our dental team for your dental care! We will strive to provide you with the best possible dental care. To help us meet your dental healthcare needs, please COMPLETE this form in ink and sign below!

PATIENT INFORMATION(please print):

Name: _____ Nickname: _____ Date of Birth: _____

Address(NO PO Boxes):_____City:_____ State/Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ Driver's License #: _____ ***Please allow us to make a copy!***

e-mail: _____ How did you find out about our office: _____

____Minor ____Single ____Married ____Separated ____Divorced ____Widowed

If full-time college student, name of college: _____ City: _____ State: _____

RESPONSIBLE PARTY:

Name of person responsible for this account: _____ Relationship: _____

If different from above:

Address: _____City:_____ State/Zip: _____

Date of Birth: _____ Employer: _____ Ofc. Number:_____

Is the patient/family covered under by any insurance? _____
If so, please complete the insurance information form. You are responsible for the estimated portion of your co-payment at the time of treatment.

FINANCIAL POLICY/ARRANGEMENTS:

PAYMENT/CO-INSURANCE FOR TREATMENT IS DUE AT THE TIME OF TREATMENT.

For your convenience, we offer the following methods of payment. Please indicate your preference

_____Cash _____Check _____Visa/MC/Discover _____CareCredit(ask for details)

*Returned check fee of $25
*Balances older than 30 days are subject to service charge of 1.25% per month(15% per year)

***Fees will be charged for broken appointments with less than 24 hours notice**

By signing below you acknowledge the information provided is true and correct and agree to be financially responsible for any balance including but not limited to unpaid insurance claims, underpaid insurance claims and those fees associated with the account being sent for collection by an outside party. I have been informed of and/or received a copy of this offices "Notice of Privacy Practices"

_____ _____ _____

Signature **Printed Name** **Date**

Dental History

Purpose of this appointment: _____
Date of last dental appointment: _____
Previous Dentist: _____ Phone Number: _____

	YES	NO
Have you experienced any undesirable reaction from dental care?	_____	_____
Are you dissatisfied with the appearance of your teeth?	_____	_____
Are you dissatisfied with the function of your teeth?	_____	_____
Has fear kept you from having regular dental care?	_____	_____
Are you dissatisfied with your past dental care?	_____	_____
Is there a history of trauma or injury to your mouth?	_____	_____
Are you concerned about any special dental problems?	_____	_____

Please describe: _____

MEDICAL HISTORY (Please check all that apply)

	Yes	No		Yes	No		Yes	No
Blood Transfusion			**Hepatitis/ Liver Disease**			**Heart Murmur**		
Prosthetic Joint			**AIDS/HIV Positive**			**Abnormal Heart Condition/Valve**		
Past/Present Tobacco Use			**Drug or Alcohol Abuse**			**Clicking or Popping of Jaw**		
Diabetes			**Tuberculosis TB Test Positive**			**Abnormal Bleeding from Cut or extraction**		
Seizure Disorder			**Rheumatic Heart Disease**			**High/Low Blood Pressure**		
Anemia			**IV Drug Abuse**			**Ear Infections**		
Asthma			**Epilepsy**			**Brain Injury**		
History of Braces			**Removal of Wisdom Teeth**			**Sinus Problems**		
Sexually Transmitted Disease			**WOMEN: Are you pregnant:**			**If Yes, how far along?_____ Any complications:**		

Do you have any allergies to the following: Penicillin___ Codeine___ Aspirin___ Latex___
Other medications/drug allergies (please specify): _____

_____

Weight: _____Birthdate: _____Currently taking any medications: _____ If so, what?

_____

Have you had any surgeries, if so, for what and when: _____

_____

Are you under the care of a physician or receiving care for another physical condition?

_____

_____ _____
Signature Date