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(DI	ease print):				
Name:		Nickname:		Date of Birth:	
Address(NO PO Boxes):			City:		State/Zip:
Home Phone:	Ce	ell Phone:		Work Phone:	
SSN:	Driver's	License #:		Please al	low us to make a copy!
e-mail:		How did y	ou find out about	our office:	
Minor	Single _	Married _	Separated _	Divorced	Widowed
If full-time college student,	name of colle	ge:	City	/:	_ State:
RESPONSIBLE PARTY:					
Name of person responsibl	e for this acco	ount:		Relations	hip:
If different from above:					
Address:			_City:	Sta	nte/Zip:
Date of Birth:	Em	nployer:		Ofc. Number:	
	stimated porti		ormation form. Yo payment at the tim		
PAYMENT/CO-I *For your con	NSURANCE nvenience, we offer CashChe	er the following me eckVisa/M arge of 1.25% per m		ease indicate your p reCredit(ask for deta	reference* ails)
*Fees will be charged f	or broken a	ppointments	s with less than	24 hours not	ice
By signing below you acknow any balance including but no with the account being sent offices "Notice of Privacy Pra	t limited to unp for collection b	oaid insurance o	claims, underpaid ir	nsurance claims	and those fees associated
Oliverature		was a New			
Signature	Prii	nted Name		Date	9

Dental History

Blood Transfusion Prosthetic Joint AIDS/HIV Positive Ald Abnormal Heart Condition/Valve Past/Present Tobacco Use Diabetes Tuberculosis TB Test Positive Anemia IV Drug Abuse Braces Bra										of this appoi	
Are 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? Are you dissatisfied with your past dental care? Are you dissatisfied with your past dental care? Are you dissatisfied with your past dental care? Are you concerned about any special dental problems? MEDICAL HISTORY (Please check all that apply) Meast Mark apply Meast Mark apply Abnormal Bleeding from Cut or extraction High/Low Blood Pressure Disorder Disease Brain Injury History of Removal of Wisdom Teeth Sinus Problems Meast Mark apply Member: Sexually Transmitted Disease Are you pregnant: MOMEN: Are you pregnant: MOMEN: Any complications: MEDICAL HISTORY (Please check all that apply) Momen: Any complications: MEDICAL HISTORY (Please check all that apply) Momen: Allos/HIV Positive Conditions MEDICAL HISTORY Abnormal Bleeding from Cut or extraction from Cut or extract				Phone Number:	P						
Are you dissatisfied with the appearance of your teeth? Are you dissatisfied with the function of your teeth? Alas fear kept you from having regular dental care? Are you dissatisfied with your past dental care? So there a history of trauma or injury to your mouth? Are you concerned about any special dental problems? MEDICAL HISTORY (Please check all that apply) Medical Hepatitis/ Albormal Heart Albormal Heart Condition/Valve Albormal Heart Condition/Valve Albormal Bleeding From Cut or extraction Albuse Brain Injury Albuse Albu		0	N	YES							
Anomia No pressure No pres		_	- -	ntal care?	eth?	our te	ppearance of ye	the a	with	dissatisfied	re you
MEDICAL HISTORY (Please check all that apply) Yes No		_	_		2	e?	past dental car	your	with	dissatisfied	re you
Yes No Hepatitis/ Liver Disease Heart Murmur						roble	special dental p	any	about	concerned a	re you
Blood Transfusion Prosthetic Joint AIDS/HIV Positive AlDs/HIV Positive ADnormal Heart Condition/Valve Clicking or Popping of Jaw Diabetes Tuberculosis TB Test Positive From Cut or extraction Fressure Alemia IV Drug Abuse Asthma Epilepsy History of Braces Sexually Transmitted Disease MOMEN: Are you pregnant: Are you have any allergies to the following: Penicillin Codeine Asthma allergies Courrently taking any medications: If so Removal of Momens Aspirin Latex Condition/Valve Abnormal Heart Condition/Valve Clicking or Popping of Abnormal Bleeding from Cut or extraction High/Low Blood Pressure Brain Injury Brain Injury Fransmit Injury Fransmitted Disease O you have any allergies to the following: Penicillin Codeine Aspirin Latex Latex Liver Disease Removal of Wisdom Testh Are you pregnant: Disease O you have any allergies to the following: Penicillin Codeine Aspirin Latex Liver Mannand Condition/Valve Clicking or Popping of Abnormal Heart Condition/Valve Clicking or Popping of Colicking or Popping of Abnormal Heart Condition/Valve Clicking or Popping of Colicking or Popping of Colicking or Popping of Colicking or Popping of Clicking or Popping of Colicking or Popping of Clicking or Popping of Abnormal Bleeding From Cut or extraction High/Low Blood Pressure High/Low Blood Pressure Brain Injury Franch High/Low Blood Pressure High/Low Blood Press				k all that apply)	check	lease	AL HISTORY (P	EDIC	M		
Transfusion	0	No	Yes		No	Yes		No	Yes		
Doubstand				Heart Murmur						Transfusion	
Tobacco Use							AIDS/HIV Positive				
Seizure Disorder Rheumatic Heart Disease Pressure Anemia IV Drug Abuse Ear Infections Asthma Epilepsy Brain Injury History of Removal of Braces Wisdom Teeth Pressure Sexually Transmitted Disease Are you pregnant: Disease Pressure TB Test Positive from Cut or extraction											
Anemia				from Cut or extraction						Diabetes	
Asthma											
History of Braces Removal of Wisdom Teeth Sinus Problems Sexually Transmitted Disease Are you pregnant: Codeine Aspirin Latex her medications/drug allergies (please specify): Currently taking any medications: If so		<u> </u>		Ear Infections			IV Drug Abuse			Anemia	
Braces Wisdom Teeth If Yes, how far along? Any complications: Disease Are you pregnant: Codeine Aspirin Latex her medications/drug allergies (please specify): Birthdate: Currently taking any medications: If so		<u></u>		Brain Injury						Asthma	
Transmitted Disease		Ī		Sinus Problems						-	
ther medications/drug allergies (please specify): eight:Birthdate:Currently taking any medications: If so				along?			-			Transmitted	
ther medications/drug allergies (please specify): eight:Birthdate:Currently taking any medications: If so											
	, what?	f so,	I	nedications:	any me	aking	Currently t	:	ndate	Birtl	eight:
ave you had any surgeries, if so, for what and when:						vhen: _	o, for what and w	s, if so	rgerie	u had any sui	ave you
re you under the care of a physician or receiving care for another physical condition?											

Signature

Date