

## 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).

\*You agree to reimburse us any fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including possible reasonable attorney's fees, we incur in such collection efforts.

**\*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: \_\_\_\_\_

	<b>YES</b>	<b>NO</b>
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			<b>WOMEN:</b> 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 \_\_\_\_\_