Laser Family Dental
41069 Dequindre Road
Suite 101
Troy MI 48085

(248)250-9333

Laserfamilydental.net

Laserfamilydental@yahoo.com

Responsible Party

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Is this person currently a patient in our office?

◯ Yes ◯ No

Relationship to Patient:

_____

E-Mail:

_____

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check

☐ Visa ☐ MasterCard

☐ I wish to discuss the office's payment policy

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Insurance Information

Primary Dental Insurance:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

How much is your deductible? How much have you used? What is your Max?

_____

Do you have any additional insurance?

◯ Yes ◯ No

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If yes, complete the following:

Name of Insured: _____ (Last) _____ (First) _____ (MI)

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ (City) _____ (State) _____ (Zip Code)

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Patient Medical History

Physician, Name and Address:

Date of Last Medical exam:

Are you under medical treatment now?

◯ Yes ◯ No

Have you ever been hospitalized for any surgical opertation or serious illness within the last 5 years?

◯ Yes ◯ No

If yes, please explain:

Are you taking any medication(s) including non-prescription medicine? Please list all:

Have you ever been treated with any of the following:

☐ Actonel ☐ Aredia ☐ Boniva ☐ Coumadin
☐ Dexfenfluramine ☐ Zometa ☐ Fosamax ☐ Fen-phen
☐ Levoxyl ☐ Pondimin ☐ Redux ☐ Synthroid
☐ Warfarin

Have you ever had a joint replacement (hip, knee, shoulder, or ankle)? If yes - when

Do you have a family history (consider grandparents, parents, siblings) that have the following?

☐ Asthma ☐ Bleeding Disorders ☐ Cancer
☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure
☐ Kidney Disease ☐ Liver Disease ☐ Seizures
☐ Stroke

Have you ever had chemotherapy? If yes, when and for what?

Have you ever had radiation treatment? If yes, to what part of your body and when?

Do you or have you used the following:

☐ Chew Tobacco ☐ Cigarettes ☐ Cigars ☐ Pipe

☐ Recreational Drugs

If you checked any of the previous box, please indicate how long used, if quit how long.

Is there any other diseases, conditions, or problems with your health that we should know about?

Have you ever had any serious illness, operation, or been hospitalized in the past? If so, what was the illness or problem?

Are you on any steroid medications or have you ever been on steroid medications?

◯ Yes ◯ No

Please check any of the following conditions that you have or had applied to you:

☐ Heart disease	☐ Congenital heart lesion	☐ Rheumatic fever
☐ Rheumatic heart disease	☐ Heart valve repair	☐ Heart valve replacement
☐ Swollen ankles/feet	☐ Shortness of breath	☐ Chest pain
☐ AICD (cardiac defibrillator)	☐ Aneurysm repair	☐ Use of inhaler
☐ COPD	☐ Persistent cough	☐ Cough (produces blood)
☐ Splenectomy	☐ Jaundice	☐ Crohn's Disease
☐ Ulcerative colitis	☐ Arthritis	☐ Joint pain
☐ Sickle cell disease	☐ G-6PD deficiency	☐ Autoimmune disease
☐ Rheumatoid arthritis	☐ Immune system prob	☐ Persistent diarrhea

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- [ ] Recent weight loss
- [ ] Swollen glands in neck
- [ ] Blood transfusion

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Alzheimer
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Bipolar
- [ ] Blood Disease
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Dizziness
- [ ] Eating Disorder
- [ ] Endocarditis
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Glaucoma
- [ ] Hayfever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis A,B,C
- [ ] High Blood Pressure
- [ ] HIV Positive
- [ ] Hives or skin rash
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Low Blood pressure
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Organ transplant
- [ ] Other- Noted
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Stent Placement
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Please check any of the following conditions that apply to you:

- [ ] Abnormal bleeding with dental work
- [ ] Allergy, Barbiturates
- [ ] Allergy, Local Anesthetics
- [ ] Allergy, Metal
- [ ] Allergy, Plastic
- [ ] Allergy, Sedatives
- [ ] Allergy, Sleeping pills
- [ ] Allery, Iodine
- [ ] Bad Breath
- [ ] Bite Cheeks
- [ ] Bleeding Gums
- [ ] Chipped or injured teeth
- [ ] Clench or grind your teeth
- [ ] Clicking or popping of jaw
- [ ] Concerned about cooked or protruding teeth
- [ ] Concemed about jaw development
- [ ] Difficulty breathing
- [ ] Difficult extractions in the past
- [ ] Difficulty in opening jaw or chewing
- [ ] Dry Mouth
- [ ] Food collection between teeth
- [ ] Frequent canker sores

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- ☐ Frequent Headaches
- ☐ Gum boils
- ☐ Have had orthodontic treatment
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Problems with previous dental treatement
- ☐ Sensitivity to heat
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth
- ☐ Treated for TMJ problem
- ☐ Wear Lower Denture
- ☐ Wisdom teeth problems
- ☐ Grinding teeth
- ☐ Had jaw surgery
- ☐ History of missing or extra teeth
- ☐ Mouth breather
- ☐ Press your tongue against teeth
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Snoring
- ☐ Thumb sucker
- ☐ Wear a removable dental appliance
- ☐ Wear Upper Denture

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Patient Dental History

Former Dentist (Name and Address):

Date of most recent dental exam:

Date of last dental X-rays:

Reason for today's visit:

Do you like your smile?

◯ Yes ◯ No

Do your gums bleed while brushing or flossing?

◯ Yes ◯ No

Are your teeth sensitive to hot or cold liquids?foods?

◯ Yes ◯ No

Are your teeth sensitive to sweet or sour liquids/foods?

◯ Yes ◯ No

Do you feel pain to any of your teeth?

◯ Yes ◯ No

Do you have any sores or lumps in or near your mouth?

◯ Yes ◯ No

Have you had any head, neck or jaw injuries?

◯ Yes ◯ No

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Have you ever experienced any of the following problems in your jaw?

☐ Pain ☐ Difficulty opening ☐ Difficulty closing ☐ Difficulty chewing

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Women Only

Please indicate if you are pregnant or anticipating becoming pregnant. Also if you are nursing or taking any birth control pills.

Authorization and Release

I certify that I have read and understand the abo ve information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I certify that if my dependents or I have insurance coverage that they are assigned directly to Dr. Nezih Jajou Bachuri D.M.D., Laser Family Dental. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

☐ I acknowledge that my questions, if any, about the above inquires 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, parent, or guardian (responsible party):

Signature: _____ Date:

Relationship to Patient:

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Comments or significant findings from patient interview concerning medical/dental history:

Dental management considerations:

Nezih Jajou-Bachuri DMD

Signature: _____ Date:

Response Date:

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Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) _____ (State) _____ (Zip Code)

SS#

_____

If Student, Name and Address of School/College:

_____

If Student:

☐ Full Time ☐ Part Time

Whom may we thank for referring you?

_____

Person to contact in case of emergency:

_____