Dr. Aziz A. Majid D.M.D.,M.S.D.PC.
You have gone to the rest, now come to the best

3540 North Progress Avenue
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717-652-5288
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Patient's Information:

PATIENT'S NAME: Mr/Mrs/Ms _____
ADDRESS: _____
_____ **E-Mail:** _____
Cell: _____ **HOME PHONE** _____
BIRTHDATE: _____ **SOC.SEC.NO:** _____
REFERRED BY: _____

PERSON RESPONSIBLE FOR PAYMENT: _____
MAILING ADDRESS: _____
SOC.SEC.NO: _____ **RELATIONSHIP TO YOU:** _____

EMPLOYER'S NAME: _____
ADDRESS: _____
_____
EMPLOYER'S PHONE: _____

PRIMARY DENTAL INSURANCE COVERAGE

NAME: _____
ADDRESS: _____
_____
PHONE: _____
PLAN ID & GROUP: _____
IS COVERAGE THROUGH EMPLOYER? YES _____ **NO** _____

SECONDARY DENTAL INSURANCE COVERAGE

NAME: _____
ADDRESS: _____
_____
PHONE: _____
IS COVERAGE THROUGH EMPLOYER? YES _____ **NO** _____

I/WE AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM. I/WE REQUEST THAT ANY PAYMENT OF INSURANCE BENEFITS BE PAID TO DR. AZIZ A. MAJID D.M.D.;M.S.D. I/WE ALSO UNDERSTAND THAT IF FOR ANY REASON, THE INSURANCE COMPANY DOESN'T PAY FOR SERVICES, OR IF THEY ONLY PROVIDE PARTIAL PAYMENT, THAT I/WE WILL BE RESPONSIBLE FOR THE SAME. I/WE AGREE 1½ % INTEREST PER MONTH ON ANY OUTSTANDING BALANCE AND ATTORNEY FEES.
BEFORE TREATMENT CAN BEGIN, THIS AGREEMENT MUST BE SIGNED BY THE DENTAL INSURANCE HOLDER AS THE RESPONSIBLE PERSON, ALONG WITH THE PATIENT, IN THE EVENT THAT PATIENT IS NOT ALSO THE DENTAL INSURANCE CONTRACT HOLDER.

PATIENT'S SIGNATURE _____

RESPONSIBLE PERSON'S SIGNATURE _____ **DATE:**_____

HEALTH HISTORY

PATIENT'S NAME: _____

Name of Medical Doctor:_____PHONE NO.:_____

Has there been any change in your general health in the past year? Yes ☐ No ☐

If Yes, Explain:_____

Have you been hospitalized in past two years: yes ☐ No ☐

If yes, Explain _____

Do you bleed excessively when cut? Yes ☐ No ☐.

Do you use tobacco? Yes ☐ No ☐. If Yes, how long _____

Are you in a substance abuse, recovery program? _____

Please list all medications you are currently taking including organic, nutritional supplement. _____

_____

Do you take Aspirin or blood thinners? Yes ☐ No ☐

Circle any of the following which you have had or now have and the date of diagnosis.

AIDS	Heart murmur	Psychiatric treatment
Anemia	Heart surgery	Pacemaker
Artificial heart valves	Heart trouble	Rheumatic fever
Asthma	High blood pressure	Stroke
Bleed easily	HIV positive	Tuberculosis
Cancer or Tumor	Joint replacement	Ulcers
Diabetes	Kidney disease	Vereneal Disease
Epilepsy/ Seizures	Liver disease	None of the above
Glaucoma	Sleep Apnea	

Circle any of the following which you are allergic to:

Latex gloves	Penicillin	Local anesthetic
other antibiotics	Any other allergies	

Is there anything related to your medical history that you have not indicated above? Yes ☐ No ☐ _____

DENTAL HISTORY

Do you have any present dental complains? Yes ☐ No ☐ Where _____

_____

_____

How long has it been since you have been to a dentist? _____

What was done then? _____

Did you have X-rays taken? Yes ☐ No ☐. Date of last cleaning _____

Have you been instructed in caring for your gums? Yes ☐ No ☐

I consent to whatever Dental Procedures and anesthetics for the treatment of the above named patient. I also agree to full Financial Responsibility for all treatment rendered.

SIGNATURE:_____ **DATE:**_____

Patient Information

How do you presently take care of your teeth and gums? Toothbrush: Hard □ Soft □ Electric □

How often? _____ Do you use dental floss? _____ How often? _____

Do you have bleeding gums or any other gum condition? _____

Have you ever had gum treatment? ……..Yes □ No □

Are your teeth sensitive to ……. Heat □ Cold □ Sweets □

Do you feel you have bad breath or unpleasant taste in your mouth at times? ……..... Yes □ No □

Do you like the alignment, color, shape of your teeth, your smile? ……..Yes □ No □

Have you lost any teeth? …….Yes □ No □.

Any complications from extractions? …….. Yes □ No □

Does food wedge between your teeth? ……Yes □ No □.

If yes, where _____

Have they ever been replaced with a fixed bridge, implants, removable partial, and dentures?

_____

Have you had your teeth straightened? Yes □ No □. If yes, When _____

Are there old fillings or dental work that you don't like looking at?..... Yes □ No □

Would you like to have your silver fillings replaced by tooth color fillings? …….Yes □ No□

Are you aware of any swelling or lump in your mouth? …… Yes □ No □

Do you hear clicking or popping noises when you chew? _____

Do you have any fear about dentistry being done? Yes □ No □. If yes, Why _____

What is your dental goal? _____

Are you interested in a lifetime strategy for dental health? _____

What would you like to change the most in the appearance of your teeth? _____

_____