Dr. Samie Thabet, DMD MSD PA

20680 Seneca Meadows Parkway, Suite 207, Germantown, MD 20876

Tel:301-515-8500 / Fax: 301-515-8501

Email:braces@thabetorthodontics.com

Patient Information

Date_____Email Address_____

Patient's Name_____
First MI Last

Address _____City_____State_____Zip_____

Sex: Male or Female Birthdate _____Social Security #_____ Marital Status_____

Home Phone _____Cell Phone_____ Work Phone_____

Employer/School Name_____

Minors: Mother's Name_____Father's Name: _____

Marital Status of Parents_____

Whom may we thank for referring you to our office? _____

Patient's Dentist_____ Dentist Phone _____ Last Visit_____

Emergency Information

Name_____Phone_____Relationship_____

Responsible Party Information *(IF NOT PATIENT)*

Name_____E-mail address_____

Address _____City_____State_____Zip_____

Home Phone _____Work Phone_____ Cell Phone _____

Social Security # _____ Birthdate_____ Relationship to Patient _____

Employer name_____

Dental Insurance Information *[Please provide insurance card(s) for us to photocopy]*

Insured's Name_____Insured's Social Security # _____DOB_____

Insurance Company_____Subscriber ID_____ Group # _____

Insurance Co. Address_____Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Secondary Insured's Name_____Insured's Social Security # _____DOB_____

Insurance Company_____Subscriber ID_____ Group # _____

Insurance Co. Address_____Phone No. _____

Medical History

Physician _____ Date of Last Visit_____

Address _____ Phone _____

Please circle Yes or No *(If Yes, please list the details).* Parents/Guardians please respond for minors.

Yes No Are you allergic to any medication/foods/latex/metals/acrylics/anesthetics etc.? _____

Yes No Are you taking any medication/supplements/herbals? _____

Yes No Does your physician recommend premedicating with antibiotics prior to dental procedures?_____

Yes No Do you have a history of a major illness?_____

Yes No Have you had any major operations or been hospitalized for any reason?_____

Yes No Have you ever been involved in a serious accident? _____

Yes No Are you/have you taking/taken bisphosphonates for osteoporosis or other bone diseases?_____

Yes No Do you chew or smoke tobacco products? If so, how long? _____

Yes No Do you have or have you ever had a substance abuse problem?_____

Circle any of the medical conditions below that you have had or currently have.

Abnormal bleeding/Hemophilia	Difficulty breathing	Hepatitis/Liver problems	Severe/Frequent headaches
Anemia	Dizziness	High/Low Blood Pressure	Shingles
Arthritis	Emphysema	HIV / AIDS	Sickle Cell Disease
Artificial bones/joints/valves	Epilepsy/seizures/fainting	Kidney problems	Sinus Problems
Asthma or Hay fever	Fever blisters/Herpes	Mitral Valve Prolapse	Tuberculosis (TB)
Blood transfusion	Gastrointestinal Disorders	Nervous Disorders	Ulcers/Colitis
Bone Disorders	Glaucoma	Pneumonia	
Cancer/Radiation/Chemotherapy	Heart attack/Stroke	Prolonged Bleeding	
Congenital Heart Defect	Heart Murmur	Psychiatric Illness	
Diabetes	Hemophilia	Rheumatic/Scarlet Fever	

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

Yes No If the patient is under age 16, height of parents? Mom_____ Dad_____

Yes No Has there been any significant growth recently? If yes, please describe_____

Female Patients only:

Yes No Are you pregnant? Yes No Nursing?

Yes No Has menstruation started? If yes, at what age? _____

Dental History *(Please include any important details for each question)*

What concerns you most about your teeth?_____

What is your attitude toward receiving orthodontic treatment? _____

Yes No Have you ever seen an orthodontist? If yes, who and when? _____

Yes No Has anyone in your family received orthodontic treatment? _____

How did they feel about the result? _____

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry?_____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there been any injuries to face, mouth or teeth?_____

Yes No Is any part of your mouth sensitive to temperature or pressure?_____

Yes No Do your gums bleed when you brush?_____

Yes No Do you have any type of thumb or finger sucking habit? _____

Yes No Do you bite your nails? _____

Yes No Are you a mouth breather? If yes, please circle: While awake While asleep_____

Yes No Do you have/have you had a tonsil or adenoid conditions?_____

Yes No Have you been told you have a tongue thrust? _____

Yes No Do you have a history of pain in your jaw joint (TMJ/TMD)?_____

Yes No Are you aware of clenching your teeth during the day? _____

Yes No Have you ever been told that you grind your teeth?_____

Yes No Do you have “tension” headaches? _____

Yes No Have you ever experienced chronic ringing in your ears? _____

Yes No Do you have any speech problems? _____

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes to the medical or dental history, I will so inform this practice.

Notice of Privacy Practices:

You have the right to read the notice of privacy practices which provides a description of office treatment, payment, activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use patient photos for demonstration and educational purposes.

Patient Rights:

You have the right to look at or get copies of your health information with limited exceptions. I gran my permission to you and or your assignee, to telephone me at home or work to discuss matters related to this form or treatment.

Consent for Services:

We schedule appointment times specific to your treatment needs. These times are reserved just for you. ***If you are unable to come to an appointment, please give us at least 24 hours notice*** so that we may accommodate other patients. If Thabet Orthodontics does not receive 24 hours notice from you for a broken appointment, please understand there may be a fee associated with the missed appointment.

At Thabet Orthodontics we make every effort to provide you with the finest orthodontic care and the most convenient financial options. To accomplish this goal, we work hand-in-hand with you to maximize your insurance reimbursement for covered procedures.

I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents. I authorize and hereby request my insurance company to pay directly to Thabet Orthodontics insurance benefits otherwise payable to me for orthodontic services. I understand that my insurance is a contract between myself and the insurance company and will make every effort to insure the insurance company has all the information needed by me to make timely payments. I agree to pay all fees my insurance company does not cover.

By signing below, I acknowledge that I have read and agree to accept the terms of the policy statements listed above and that to the best of my knowledge, all of the preceding answers are true and correct. If any of the above changes, I will inform the doctor at my next appointment.

_____

Signature of Patient, Parent, or Guardian Date Relationship to Patient

_____

Dr. Samie Thabet DMD, MSD, PA Date