

DENTAL REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
 Last Name _____
 First Name _____ Middle Initial _____

Address _____

E-mail _____

City _____

State _____ Zip _____

Sex M F Age _____

Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Patient Employer/School _____

Occupation _____

Employer/School Address _____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE
 I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
 Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. 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.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Date

 Relationship to Patient

3 PHONE NUMBERS

Phone (____) _____ Work (____) _____ Ext _____ Cell (____) _____

Spouse's Work (____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone (____) _____ Work Phone (____) _____

4 DENTAL HISTORY

| | | |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| Reason for today's visit _____ | Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| _____ | Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Former Dentist _____ | Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| City/State _____ | Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental visit _____ | Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Date of last dental X-rays _____ | Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Place a mark on "yes" or "no" to indicate if you have had any of the following: | Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No | Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No | Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No | Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No | Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you floss? _____ |
| | Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No | How often do you brush? _____ |
| | Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No | |

5

HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. Yes No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | |
|--------------------------------------------------|----------------------------------------------------------|-----------------------|----------------------------------------------------------|---------------------------------|----------------------------------------------------------|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis, Rheumatism | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, with extractions or surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Neck Glands | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Do you wear contact lenses? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Women:

Are you pregnant? Yes No Due date _____ Are you nursing? Yes No
 Taking birth control pills? Yes No

MEDICATIONS

ALLERGIES

List any medications you are currently taking and the correlating diagnosis:

 Pharmacy Name _____
 Phone (_____) _____

- | | |
|--------------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic |
| <input type="checkbox"/> Barbiturates (Sleeping pills) | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Latex | _____ |

6

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Has there been any change in your health since your last dental appointment? Yes No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL TREATMENT CONSENT

Please read and initial the items checked below
Read and sign the section at the bottom of the form.

Patient Name _____

1. DIAGNOSTIC AND PREVENTITIVE

(INITIALS _____)

I understand that I am having the following work done: X-rays _____ Cleaning _____ Exam _____ Other _____

2. DRUGS AND MEDICATIONS

(INITIALS _____)

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. NITROUS OXIDE

(INITIALS _____)

I understand that nitrous oxide (laughing gas) provides relaxation to make it more comfortable for me to receive the necessary dental care with less anxiety. I will be fully awake, fully conscious, aware of my surroundings, and able to respond rationally. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history.

4. LOCAL ANESTHETIC

(INITIALS _____)

I understand there are risks of local anesthetics that may affect my body such as dizziness, nausea, vomiting, accelerated or slowed heartbeat, or various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness, or tingling that may persist for several weeks, months, or rarely, be permanent. I have informed my doctor of my complete medical history including any recent surgeries or changes in medical history.

5. REMOVAL OF TEETH

(INITIALS _____)

Alternatives to removal have been explained to me and I authorize the dentist to remove the following teeth _____. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, and some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue that can last for an indefinite period of time (days of months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

6. CROWN AND BRIDGES

(INITIALS _____)

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size and color) will be before cementation.

7. DENTURES, COMPLETE OR PARTIAL

(INITIALS _____)

I realize that full or partial dentures are artificial, constructed of acrylic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me; include looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost of the procedure is not included in the initial denture fee.

8. ENDODONTIC TREATMENT (ROOT CANAL)

(INITIALS _____)

I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment, and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

We invite you to discuss any questions regarding our services with us. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the office manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made you will be responsible for legal fees, collection agency fees, interest charges or any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any and all changes to this information. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask question. My questions have been answered to my satisfaction. I am signing below that I have read and understood this form.

Signature of Patient _____

Date _____

DR.NAHHEL YANNI
385 CRANBURY ROAD EAST BRUNSWICK, NJ 08816
PHONE: 732-254-0033 FAX: 732-238-8869

Welcome to the office of Dr. Nahel Yanni! Thank you for choosing us for your dental health. Our mission is to enhance your overall dental health. We promise to provide you with excellent care and respect.

We want you to completely understand our financial policies, so here they are:

We need your credit card on file, where we will keep it safe in case we need to charge any of the following fees:

| | |
|--------------------------------------------------------|--------------------------------------|
| CANCELLATION FEE LESS THAN 24 HOURS | \$50 HYGENIST/\$150 DR.YANNI |
| NO SHOW FEE | \$50 HYGENIST/ \$150 DR.YANNI |
| RETURNED CHECK FEE | \$35.00 |
| BALANCE AFTER YOUR INSURANCE PAYS THEIR PORTION | |

Don't worry; you can avoid the above mentioned fees! If you need to cancel your appointment, simply notify our administrative staff within 24 hours of your appointment time. To avoid the no show fee simply let us know within 24 hours that you cannot make it or show up for your scheduled appointments, as we have reserved the time just for you!

Insurance: As a courtesy, we file insurance. It is your responsibility to notify us of any changes to your insurance coverage. This is your insurance policy and we require that you know your benefits regarding maximum, waiting periods, benefit year, and deductibles. Please know that any information required from your insurance company regarding the treatments done will be provided by us as it is requested. Any dental and medical insurance payments will go directly to Dr. Yanni and will be applied to your account. If you receive any payment from either your dental or medical insurance we ask that you forward them to Dr. Yanni.

| | | | | |
|-----------------------------|------|------------------|-----------|-------------|
| PAYMENT INFORMATION | | | | |
| MASTERCARD | VISA | AMERICAN EXPRESS | DISCOVER | CARE CREDIT |
| NAME AS IT APPEARS ON CARD: | | | | |
| CARD NUMBER: | | | EXP DATE: | |
| BILLING ADDRESS: | | | | |
| EMERGENCY CONTACT NAME: | | | PHONE: | |
| SIGNATURE | | | | |

I have read and fully understand Dr. Nahel Yanni's financial policies. I acknowledge full responsibility for services rendered by Dr. Nahel Yanni.

_____ Yes! I would like to receive courtesy appointment reminders via email and text messaging.

Signature _____

Date: _____