Dr. Jehan Wakeem
28130 Harper Ave. St. Clair Shores , MI 48081

PATIENT INFORMATION

NAME__________ BIRTHDAY__________ SS# SIN__________
ADDRESS__________CITY__________STATE__________ZIP__________
EMAIL__________HOME PHONE__________CELL PHONE__________

MINOR____ SINGLE____ MARRIED____ DIVORCED____ WIDOWED____ SEPARATED____

SPOUSE / PARENT/ GUARDIAN'S NAME__________ CELL PHONE__________
NAME OF SCHOOL / COLLEGE__________CITY__________ STATE__________ PART_____ FULL_____
PATIENT OR PARENT'S EMPLOYER__________ WORK PHONE__________
ADDRESS__________CITY__________ STATE__________ZIP__________
EMERGENCY CONTACT__________ CELL PHONE__________

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT__________
RELATIONSHIP TO PATIENT__________ IS THIS PERSON ALSO A PATIENT? Y__________ N__________
ADDRESS__________CITY__________STATE__________ZIP__________
EMAIL__________HOME PHONE__________CELL PHONE__________
DRIVER'S LICENSE #__________ BIRTHDATE__________FINANCIAL INSTITUTION__________
EMPLOYER__________ WORK PHONE__________SSN__________
CHOOSE THE PAYMENT METHOD YOU PREFER
CASH__________ CHECK__________ CREDIT CARD: VISA__________ MASTERCARD__________ I WISH TO DISCUSS__________

INSURANCE INFORMATION

NAME OF PERSON INSURED__________
RELATIONSHIP TO PATIENT__________ IS THIS PERSON ALSO A PATIENT? Y__________ N__________
ADDRESS__________CITY__________STATE__________ZIP__________
EMAIL__________HOME PHONE__________CELL PHONE__________
BIRTHDATE__________EMPLOYER__________ SSN__________
EMPLOYER ADDRESS__________CITY__________STATE__________ZIP__________
INS. CO.__________GROUP #__________POLICY / ID #__________
INS. CO. ADDRESS__________CITY__________STATE__________ZIP__________
DEDUCTABLE AMOUNT__________AMOUNT USED__________MAX ANNUAL BENEFIT__________

ANY ADDITIONAL INSURANCE__________
NAME OF PERSON INSURED__________
RELATIONSHIP TO PATIENT__________ IS THIS PERSON ALSO A PATIENT? Y__________ N__________
ADDRESS__________CITY__________STATE__________ZIP__________
EMAIL__________HOME PHONE__________CELL PHONE__________
BIRTHDATE__________EMPLOYER__________ SSN__________
EMPLOYER ADDRESS__________CITY__________STATE__________ZIP__________
INS. CO.__________GROUP #__________POLICY / ID #__________
INS. CO. ADDRESS__________CITY__________STATE__________ZIP__________
DEDUCTABLE AMOUNT__________AMOUNT USED__________MAX ANNUAL BENEFIT__________

PATIENT MEDICAL HISTORY

PHYSICIAN__________________________OFFICE PHONE_____________________________DATE OF LAST EXAM___________________

	Y	N
ARE YOU UNDER MEDICAL TREATMENT?	☐	☐
HAVE YOU BEEN HOSPITALIZED FOR ANY REASON IN THE LAST 5 YRS?	☐	☐
IF YES PLEASE EXPLAIN____________________________		
ARE YOU TAKING ANY MEDICATION? (INCLUDING NON-PRESCRIPTION)	☐	☐
IF YES, WHAT MEDICATION(S) ARE YOU TAKING?_____		
HAVE YOU EVER TAKEN FEN-PHEN/REDUX?	☐	☐
HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHATES?	☐	☐
HAVE YOU TAKEN VIAGRA, REVATIO, CIALIS, OR LEVITRA IN THE LAST 24HRS?	☐	☐
DO YOU USE TOBACCO?	☐	☐
DO YOU USE CONTROLLED SUBSTANCES?	☐	☐

	Y	N
ARE YOU WEARING CONTACT LENSES?	☐	☐
ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY OF THE FOLLOWING?		
LOCAL ANESTHETICS (e.g. NOVACAIN)	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES	☐	☐
SEDATIVES	☐	☐
IODINE	☐	☐
ASPIRIN	☐	☐
ANY METALS (e.g. NICKEL, MERCURY, ETC.)	☐	☐
LATEX RUBBER	☐	☐
OTHER?	☐	☐
DO YOU HAVE A PERSISTANT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS?	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING ORAL CONTRACEPTIVES?	☐	☐

	Y	N
HIGH BLOOD PRESSURE	☐	☐
HEART ATTACK	☐	☐
RHEUMATIC FEVER	☐	☐
SWOLLEN ANKLES	☐	☐
FAINTING / SEIZURES	☐	☐
ASTHMA	☐	☐
LOW BLOOD PRESSURE	☐	☐
EPILEPSY / CONVULSIONS	☐	☐
LEUKEMIA	☐	☐
DIABETES	☐	☐
KIDNEY DISEASES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐

	Y	N
HEART DISEASE	☐	☐
CARDIC PACEMAKER	☐	☐
HEART MURMUR	☐	☐
ANGINA	☐	☐
FREQUENTLY TIRED	☐	☐
ANEMIA	☐	☐
EMPHYSEMA	☐	☐
CANCER	☐	☐
ARTHRITIS	☐	☐
JOINT REPLACEMENT / IMPLANT	☐	☐
HEPATITIS / JAUNDICE	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
STOMACH TROUBLES / ULCERS	☐	☐

	Y	N
CHEST PAINS	☐	☐
EASILY WINDED	☐	☐
STROKE	☐	☐
HAY FEVER / ALLERGIES	☐	☐
TUBERCULOSIS	☐	☐
RADIATION THERAPY	☐	☐
GLAUCOMA	☐	☐
RECENT WEIGHT LOSS	☐	☐
LIVER DISEASE	☐	☐
HEART TROUBLE	☐	☐
RESPITORY PROBLEMS	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
OTHER________________________		

PATIENT DENTAL HISTORY

NAME OF PREVIOUS DENTIST AND LOCATION ___________________________________DATE OF LAST EXAM____________

	Y	N
DO YOUR GUMS BLEED WHILE BRUSHING ?	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT / COLD ?	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET / SOUR ?	☐	☐
DO YOU FEEL PAIN IN ANY OF YOUR TEETH ?	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR AROUND YOUR MOUTH ?	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	☐	☐
HAVE YOU EVER EXPERIENCED THE FOLLOWING JAW PROBLEMS ?		
CLICKING	☐	☐
PAIN (JOINT , EAR , SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐

	Y	N
DO YOU HAVE FREQUENT HEADACHES?	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY?	☐	☐
HAVE YOU HAD DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS ?	☐	☐
HAVE YOU HAD ANY ORTHODONTIC TREATMENT?	☐	☐
DO YOU WEAR DENTURES OR PARTIALS?	☐	☐
WHEN WERE THEY PROVIDED?_____________		
DID YOU RECEIVE ORAL HYGENE INSTRUCTIONS?	☐	☐
DO YOU LIKE YOUR SMILE?	☐	☐

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE 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 DEPENDANTS.

X____

SIGNATURE OF PATIENT (OR PARENT / GUARDIAN) DATE

DOCTORS COMMENTS____

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SIGNATURE DATE