

rmation	Mr Mrs Ms Miss Dr First Name:	Last Name:	Date o	f Birth:///	YY			
Insurance Information	Address:	Apt/Unit #City:		Postal Code:				
Itact	Home Phone:	Work:		Cell:				
t Con	Email:	Pref	erred Contact Method:					
Patien	Emergency Contact Person:		Phone Number:					
	Primary Insurance Company	/						
	Name of Policy Holder:	Date	of Birth:/	/				
	Group Policy/Plan Number:							
u	Employer: Name of Insurance Company:							
Referral Information Insurance Information Patient Contact Information	Secondary Insurance Comp	••••						
nfor	Name of Policy Holder:	Date	e of Birth:/	/				
Ce	Group Policy/Plan Number:				_			
Insurance Information	Employer:	Name of Ir	surance Company:		_			
	I, understand, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Margolian 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 hereby authorize Dr. Bishara to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.							
	Authorized Signatu * All fees or balances not covered by insurance information. We do not ha	your dental insurance policy will b	be payable at time of visit e policy information unles	. You must provide us with all ss provided to us.				
lation	How did you hear about us?	,						
nform	Facebook Internet Search	Website Referral						
erral	Family Member or Friend:							
Refe	Other:							

Referral Information

Do you have any allergies?		clenching teeth	Grinding or cl		livity	Sensitiv		
Jaw Joint Pain (clicking/cracking) Bad breath or taste in the mouth Broken Teeth or Fillings When was your last dental visit? What was done at that visit? When having dental treatment do you require sedation? nitrous oxide (laughing gas) oral medication Do you smoke or chew tobacco? If "yes" for how long?		vollen or irritated gums	Pain or Discomfort While Chewing Bleeding, swollen or irritated gums			Tooth P		
Broken Teeth or Fillings When was your last dental visit? What was done at that visit? When having dental treatment do you require sedation? nitrous oxide (laughing gas) oral medication Do you smoke or chew tobacco? If "yes" for how long? If you could change your smile, you would Make your teeth brighter/whiter Repair chipped teeth Make your teeth straighter Replace missing teeth Close spaces Replace crowns Replace fillings Have a smile makeover What is the most important thing to you about your visit today?		ifting teeth				Headac		
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Replace fillings Have a smile makeover Other:			lace missing teeth	F	your teeth str	Make yo		
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Are you currently under a physician's care? For?		re-medication for dental work?	Do you require pre	ments?	have any joint	Do you ha		
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			FUI {	SICIALI S CALE		Ale you cl		
Physician's Name and Phone Number:				Number:	an's Name and	Physician'		
Pharmacy's Name and Phone Number:				Number:	cy's Name an	Pharmacy		
I certify that I have read, understood and accurately completed the personal, medical and dental histories to the best of m and have not knowingly omitted any information. If required, I consent to my physician being contacted regarding any spe questions. I authorize Dr. Bishara to perform necessary diagnostic procedures and treatment as required to achieve prop	any specific med	my physician being contacted regarding any specif	f required, I consent to n	iny informatio	e not knowingly	and have n		

Patient Signature:

Dentist's Signature:

Dental History