DR. RANDAL BOURJAILY

WELCOME TO OUR PRACTICE

PATIENT _____
Last Name First Name Middle Initial Preferred Name Title (if any)

Street Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____ E-mail _____

Sex: _____ Birthday _____ Social Security # _____ Marital Status _____

Employer _____ Work Phone _____ Occupation _____

Emergency Contact _____ Cell Phone _____ Home Phone _____

RESPONSIBLE PARTY _____
(If parent or guardian) Last Name First Name Middle Initial

Street Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____ E-mail _____

Sex: _____ Birthday _____ Social Security # _____ Marital Status _____

Employer _____ Work Phone _____ Occupation _____

HOW DID YOU HEAR ABOUT US?

Please let us know how you heard about us: _____
If you were referred by an existing patient, please let us know so we can credit $25 to their account and to yours!

DENTAL INSURANCE INFORMATION

Name of Insured _____
Last Name First Name Middle Initial

Birthday _____ Social Security # _____ Marital Status _____

Insurance Carrier _____ Phone # _____ Group # _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Insured _____
Last Name First Name Middle Initial

Birthday _____ Social Security # _____ Marital Status _____

Insurance Carrier _____ Phone # _____ Group # _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ (Name of Minor/Child) do hereby request and authorize the dental staff to perform dental services for my child, including but not limited to X-rays and the administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Patient, Parent or Guardian Signature _____ **Date:** _____
(Must be 18 years or older to sign)

STAFF USE ONLY

Photo ID Verified	ID#/Type	State	Exp. Date

DR. RANDAL BOURJAILY

DENTAL HISTORY AND CONCERNS

Dr. Randal Bourjaily focuses on providing comprehensive care to adults and their families. We are able to deliver care that not only improves our patients' health and aesthetics but also changes their lives. We look beyond just the teeth and gums, treating the whole patient comprehensively. We seek to establish a harmonious relationship of the three main factors affecting your bite — teeth, muscles and jaw joints. An optimal bite is also essential to ensure that smile makeovers and dental restorations are beautiful, functional and long-lasting.

What is your chief complaint? _____

Does floss shred when you use it? Yes No Does food pack or catch between your teeth? Yes No

Do you smoke or chew tobacco? Yes No Do your gums bleed? Yes No

Does your breath concern you? Yes No

When was your last dental appointment and cleaning? _____

How would you rate your smile? (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)

Should you need treatment, at what point should we address it?

❏ When my tooth hurts or breaks ❏ When something is worsening ❏ Before problem occurs

Please indicate if you have any of the following concerns (check all that apply):

❏ My teeth are not in alignment ❏ I have a space I don't like ❏ I do not like the color of my teeth

❏ Chipped teeth ❏ Hidden or missing teeth ❏ Old fillings, veneers or crowns

❏ TMJ Disorder ❏ My teeth hurt ❏Overall appearance of my smile

Have you ever been told or are you aware that you snore or have sleep apnea? Yes No

Have you completed or ever been part of a sleep study? Yes No

What is the reason for trying a new dental office? _____

_____

Are there any additional concerns you would like us to know? _____

_____

_____

DR. RANDAL BOURJAILY

MEDICAL HISTORY

Although as dentists we treat the area in and around the mouth, it is part of your entire body. Medical health problems you may have or medications you may be taking could be important to you dental health. Thank you for **thoroughly** answering the following questions.

Family Physician _____ Phone # _____

Are you taking any medication now, including regular doses of aspirin? Yes No
If so, please list the name and dosage _____

Are you aware of having an allergic reaction to any medication or substance? Yes No
If so, please list (e.g. Latex, penicillin, iodine) _____

Have you been under the care of a medical doctor during the past two years? Yes No
If so, for what? _____

Have you ever had heart surgery, heart valve or joint replacement or an organ transplant? Yes No
If so, for what and when? _____

Do you require premedication (e.g. knee replacement)? Yes No If so, for what? _____

Do you or have you **ever** taken Fosamax or any other biphosphonate, Zometa, Aredia, Boniva or Actonel? Yes No

Women: Are you ❑ Pregnant? ❑ Nursing? ❑ Taking birth control pills? ❑ None

Indicate which of the following you have had or have at present by checking the box:

❑ Heart Concerns	❑ Neurological Disorders	❑ Headaches
❑ Congenital Heart Disease	❑ Osteoporosis	❑ Limited Mouth Opening
❑ Heart Murmur	❑ Liver Disease/jaundice	❑ High Blood Pressure
❑ Sickle Cell Disease	❑ Facial Pain	❑ Mitral Valve Prolapse
❑ Asthma	❑ Sensitive Teeth (hot/cold)	❑ Artificial Heart Valve
❑ AIDS/HIV	❑ Difficulty Swallowing	❑ Pacemaker
❑ Stroke	❑ Latex Allergy	❑ Angina
❑ Jaw Clicking/Popping	❑ Artificial Joints	❑ Anemia
❑ Kidney Trouble	❑ Ulcers	❑ Radiation/Chemotherapy
❑ Tuberculosis	❑ Epilepsy/Seizures	❑ Arthritis
❑ Hepatitis	❑ Difficulty Chewing	❑ Jaw Pain
❑ Psychiatric Disorders	❑ Insomnia/Nervousness	❑ Congested Ears
❑ Diabetes	❑ Teeth Clenching/Grinding	❑ Loose Teeth
❑ Thyroid Disorder	❑ Snoring/Sleep Apnea	❑ Neck Ache

Notes/Any other health issues: _____

_____

Medical Updates: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify Dr. Bourjaily of any change in health or medication.

Patient, Parent or Guardian Signature _____ **Date:** _____
(Must be 18 years or older to sign)

DR. RANDAL BOURJAILY

FINANCIAL POLICY/PAYMENT OPTIONS

Our mission is to deliver the best and most comprehensive dental care, and financial considerations should not be an obstacle in fulfilling your needs. Therefore we provide a range of payment options for our patients.

CHECK, DEBIT CARD, VISA, MASTERCARD OR DISCOVER CARD
A 5% discount for treatment plans over $1500.00 for full payment by cash or check.

DENTAL PAYMENT PLAN (Monthly payment plans including no-interest and extended period plans)
Flexible monthly payment plans are available from third party companies such as Care Credit, subject to credit approval. We are able, in many instances, to obtain credit approval on the spot, even if you have a limited or negative credit history.

INSURANCE PLANS
We accept most dental plans, and we will work to maximize your dental benefits and submit your claims at no charge. For your convenience, we accept the insurance benefit directly from your insurance company and only the estimated portion not covered by your insurance is due at the time treatment is performed. However, we make no guarantees of your insurance reimbursement, and if we do not receive payment in full from your insurance company within 60 days, you will be responsible for the unpaid insurance portion.

FLEXIBLE SPENDING ACCOUNTS
If you work for a company that provides a flexible spending account or a “flex-plan,” we will explain to you the mechanism for saving up to 35% on your treatment cost by paying with non-taxable income.

PLEASE NOTE
Your appointments have been reserved exclusively for you. If you are unable to come for your appointment, please notify our staff at least 24 hours in advance so we may offer that availability to another patient in need of treatment. If you cancel your appointment with less than 24 hours notice or are late for your appointment such that your scheduled treatment cannot be completed, your account may be charged a $25.00 cancellation fee.

A late charge of up to $25.00 may be applied to unpaid balances of 60 days or more. There will be a $25.00 charge for all returned checks.

I have read the Financial Policy in its entirety, and I understand and agree to all its terms.

Patient, Parent or Guardian Signature _____ **Date:** _____
(Must be 18 years or older to sign)