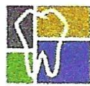


JOHN H. SATTAR, DDS
FAMILY DENTISTRY

Patient Name: ______________________ Today's Date: ______________________
Home Address: ______________________ Date of Birth: ______________________
______________________ Social Security No: ______________________
Cell Phone: ______________________ Home Phone: ______________________
Work Phone: ______________________ Email: ______________________

Patient Medical History

Physician:______________ Office Phone:______________ Date of Last Exam: ______________

	YES	NO
1)Are you under Medical Treatment Now?	☐	☐
2)Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3)Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking?

____

	YES	NO
4)Do you use tabacco?	☐	☐
5)Do you use alcohol, cocaine or other drugs?	☐	☐
6) Are you wearing contact lenses?	☐	☐

7)Are you allergic to or have you had any reactions to the followings?

	YES	NO
Local Anesthetics (e.g novocaine)	☐	☐
Penecillin or Other Antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Others	☐	☐

8)Women Only:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

Do you or you have you had any of the following?

YES	NO	
☐	☐	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 Problem

YES	NO	
☐	☐	Heart Disease
☐	☐	Cardic Pacemaker
☐	☐	Heart Murmur
☐	☐	Angina
☐	☐	Frequently Tired
☐	☐	Anemia
☐	☐	Emphysema
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Joint Replacement/Implant
☐	☐	Hepatitis/Jaundice
☐	☐	Sexually Trasmitted Disease
☐	☐	Stomach Troubles/Ulcers
☐	☐	Chest Pains

YES	NO	
☐	☐	Easily Winded
☐	☐	Stroke
☐	☐	Hay Fever/Allergies
☐	☐	Tuberculosis
☐	☐	Radiation Therapy
☐	☐	Glaucoma
☐	☐	Recent Weight Loss
☐	☐	Liver Disease
☐	☐	Heart Trouble
☐	☐	Respiratory Problems
☐	☐	Others

____
____

Patient Dental History

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensetive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensetive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
a) Clickings?	☐	☐
b) Pain(joint, ear, side or face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheecks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you had any orthodontic work?	☐	☐
13. Have you ever had prolonged bleeding following extractions?	☐	☐
14. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
15. Have you ever had instructions on the care of your gums?	☐	☐

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.

SIGNATURE :______________________________ ______________
PATIENT, PARENT OR GUARDIAN DATE

JOHN H. SATTAR, DDS
FAMILY DENTISTRY

Patient Information

Date: ______________________
First Name: ______________________
Date of Birth: ______________________
SSN: ______________________
Address: ______________________
____
Cell Phone: ______________________
Email: ______________________
SEX : F ☐ M ☐
Marital Status : ______________________
Employer: ______________________
Address: ______________________
Occupation: ______________________
Referred by : ______________________

Responsible Party Information

Full Name: ______________________
Relationship to Patient: ______________________
Date of Birth: ______________________
SSN: ______________________
Address: ______________________
____
Phone: ______________________
Email: ______________________

In Case of Emergency , Notify :

Name: ______________________
Cell Phone: ______________________
Email: ______________________

INSURANCE AND PAYMENT INFORMATION

Please provide us the copy of your ID and your dental insurance card (s).

Primary Dental Insurance Co: ______________________ ID#: ______________________

Secondary Insurance Co: ______________________ ID#: ______________________

Form of Payment : ☐ Cash ☐ Check ☐ Visa/MC

PLEASE READ AND SIGN

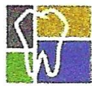
Appointment Policy: There will be a $25 charge for appointment cancelation or no show.

Financial Authorization: I understand that I am financially responsible to Dr. John Sattar for the charge incurred by myself and/or my dependents. I agree that in the event my account is past due for 60 days from the date of service, it is turned over to an attorney for collection and I will also be liable for attorney's fee in the amount of 1/3 of the Principle balance, plus all court costs. I will pay interest on accounts past due 45 days or more at the rate of 1.5% per month (18% annually).

Signature: ______________________ Date: ______________________

Dental/ Medical Insurance Authorization: I hearby assign all Medical, Dental and/or surgical benefits to which I am entitled for this service to Dr. John Sattar. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assigns to release all information necessary to secure payments.

Signature: ______________________ Date: ______________________



JOHN H. SATTAR, DDS
FAMILY DENTISTRY

Patient Name: ______________________ Today's Date: ______________________
Home Address: ______________________ Date of Birth: ______________________
______________________ Social Security No: ______________________
Cell Phone: ______________________ Home Phone: ______________________
Work Phone: ______________________ Email: ______________________

Patient Medical History

Physician:______________ Office Phone:______________ Date of Last Exam: ______________

	YES	NO
1)Are you under Medical Treatment Now?	☐	☐
2)Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3)Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? ______________________	☐	☐
4)Do you use tabacco?	☐	☐
5)Do you use alcohol, cocaine or other drugs?	☐	☐
6) Are you wearing contact lenses?	☐	☐

7)Are you allergic to or have you had any reactions to the followings?

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Sulfa drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Others	☐	☐

8)Women Only:

	YES	NO
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

Do you or you have you had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	High Blood Pressure	☐	☐	Heart Disease	☐	☐	Easily Winded
☐	☐	Heart Attack	☐	☐	Cardic Pacemaker	☐	☐	Stroke
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Hay Fever/Allergies
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Tuberculosis
☐	☐	Fainting/ Seizures	☐	☐	Frequently Tired	☐	☐	Radiation Therapy
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Glaucoma
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Recent Weight Loss
☐	☐	Epilepsy/ Convulsions	☐	☐	Cancer	☐	☐	Liver Disease
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Heart Trouble
☐	☐	Diabetes	☐	☐	Joint Replacement/Implant	☐	☐	Respiratory Problems
☐	☐	Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Others
☐	☐	AIDS or HIV Infection	☐	☐	Sexually Trasmitted Disease			______________
☐	☐	Thyroid Problem	☐	☐	Stomach Troubles/Ulcers			______________
			☐	☐	Chest Pains			

Patient Dental History

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensetive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensetive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
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b) Pain(joint, ear, side or face)?	☐	☐
c) Difficulty in opening or closing?	☐	☐
d) Difficulty in chewing?	☐	☐

	YES	NO
8. Do you have frequent headaches?	☐	☐
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11. Have you ever had any difficult extractions in the past?	☐	☐
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13. Have you ever had prolonged bleeding following extractions?	☐	☐
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15. Have you ever had instructions on the care of your gums?	☐	☐

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