

Carol M. Ysidro, DDS/Omar Barakeh, DDS

Welcome to our Office!!!

Patient Information

Patient Name: _____ Date of Birth: _____

Male Female Married Single Child Other _____ SS# _____

Phone Numbers (Home) _____ (Work) _____ (Cell) _____

Email Address: _____ *(for appointment reminders)*

Which way is best to contact you directly during the day? Home# _____ Work# _____ Cell# _____ Email _____

Address: _____

Employer Name: _____ Occupation: _____

Who may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account: _____ Date of Birth _____

Relationship to Patient: Self Parent/Guardian Other _____ SS# _____

Address: _____ Daytime Phone: _____

Name of employer: _____ Work Phone _____

Insurance Information

Subscriber Name: _____ Date of Birth: _____

SS# _____ Name of Employer: _____

Subscriber's Address: _____ Phone: _____

Name of Insurance Company _____

The above information provided is true and correct to the best of my knowledge. If I have any changes regarding the above information, I shall inform the staff on or before my next appointment without fail.

Patient Signature (Parent or Guardian if patient under age 18)

Today's Date

Health Information**Patient Name:** _____**Date:** _____**Have you ever had any of the following? Please check those that apply:**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Hemophilia (Bleeding) | <input type="checkbox"/> Ulcers | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> HIV Positive |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Swelling of Limbs | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Drug Addiction |
| <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Fainting or Dizziness |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Hepatitis (A) (B) (C) | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Alzheimer's Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Allergies _____ |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis/Gout | _____ |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Tumors or Growths | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Hives or Rash |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Venereal Disease | Due date _____ |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Genital Herpes | |

• Are you allergic to any medications or substances? Yes No If yes, please explain: _____

• Are you currently taking any medications? Yes No If yes, please list: _____

• Have you ever had any complications following dental treatment? Yes No If yes, please explain: _____

• Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
If yes, please explain: _____

• Are you now under the care of a physician? Yes No
If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Do you have any health problems that need further clarification? Yes No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian _____ Date: _____

Reviewed by Doctor _____ Date _____

History Review and Significant Findings: _____

Medical Updates

Date	List any Changes	Patient Signature	Reviewed By
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DENTAL HISTORY

Please Circle

1. Do you have a specific dental problem? Explain: _____ YES NO

2. Do you experience pain in your teeth (Hot, Cold, Sweets or Chewing)? Explain: _____ YES NO

3. Have you ever had a serious injury to your head, neck, face, jaw or teeth? Explain: _____ YES NO

4. Do you have frequent cold sores or fever blisters? _____ YES NO

5. Do you think you have decay or gum disease? _____ YES NO

6. Have you been treated for periodontal disease? _____ YES NO

7. Do your gums ever bleed? _____ YES NO

8. Do you ever have clicking, popping or discomfort in your jaw joint? Explain: _____ YES NO

9. Do you grind your teeth day or night? _____ YES NO

10. Do you awaken with teeth clenched? _____ YES NO

11. Do you have frequent headaches? _____ YES NO

12. Have you ever had orthodontic treatment? _____ YES NO

13. Have you ever worn a bite-guard or splint? _____ YES NO

14. Are you happy with your smile? If NO, what would you change? _____ YES NO

15. Do you smoke or chew? _____ YES NO

16. Are you worried about receiving dental treatment? Explain: _____ YES NO

17. When was your last dental cleaning? _____ Xrays? _____

18. How often do you brush? _____ Floss? _____

19. Do you use any other cleaning devices? Explain: _____ YES NO

20. Name of previous dentist (optional): _____

Carol M Ysidro, DDS
Omar Barakeh, DDS
PO Box 1258, 900 E Meadowlark Derby KS 67037
Phone: 316-788-2118 Fax: 316-789-9098

Our office is committed to providing you with the best possible professional care. If you have a dental benefit plan, we want to help you receive your maximum allowable benefits. We know that service to our patients is optimal when there is understanding and mutual cooperation.

Billing Policy: It is NOT our policy to lend money or carry patient balances. Therefore, payments for services are due at time services are rendered or products/materials are purchased. We accept cash, MasterCard, Visa, Discover, American Express and debit cards.

Insurance Policy: You must realize that your dental benefit plan is a contract between you, your employer and the insurance company. As a dental care provider, our relationship is with you, not your insurance company. We file your claim as a courtesy to you as long as you have provided us with current and complete information. If we are unable to verify your eligibility, you will be responsible for payment in full at the time of your visit. Remember, not all services are a covered benefit in all contracts. If you have questions or concerns about your benefits or eligibility, call your insurance company. If you have two dental benefit plans, you may only get coverage from the primary because of a "non-duplication clause".

As a courtesy we can give you an estimated amount due for your appointment. This amount is considered a guideline until the final insurance benefit payment is received and the patient's account reconciled. This office can not make any guarantee that your dental insurance will pay what was estimated.

Appointment Policy: If you arrive late for your appointment, we may reschedule your appointment if there is not sufficient time to complete your scheduled treatment. If you are unable to keep an appointment, please call us. There will be a \$50.00 charge on appointments not canceled 24 hours in advance.

Photographs : Occasionally our office will take photos for your chart, pre-operative and post-operative (before and after treatment), supporting medical documentation for claim filing and/or educational purposes for our staff and patients. Photos used for educational purposes are of the treatment area only and do not include facial portraits or names unless written consent has been given by the patient or the patients parent or guardian.

Authorization : I hereby authorize Dr. Ysidro/Dr Barakeh to release any information concerning my care to my primary care physician, family physician, referring physician or dentist or referred to physician or specialist/dentist. I acknowledge the receipt of the Notice of Privacy Practices and give consent for use and disclosure of health information. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations in this office.

Assignment of Benefits and Guarantee of Payment : I hereby authorize payment of third-party benefits, otherwise payable to me directly to Carol M. Ysidro, DDS. I understand that my dental benefit plan may pay less than the actual bill for services. I understand and agree that, I am ultimately responsible for charges for professional services and materials not paid by my dental benefit plan, regardless of my insurances' status, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I agree to pay Carol M. Ysidro, DDS as bills are presented. If I have any questions regarding how my insurance processed claims, I will contact my insurance company. Additionally, I understand I am responsible for costs associated with collecting said owed balances, including but not limited to, collection agency fees, attorney fees and court costs.

**My signature verifies I have read and understand the information presented on this page.

Patient Signature (Parent or Guardian if patient under age 18)

Today's Date