Dr. Jumana Ghorab, DDS, PC

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Our goal is to help you reach and maintain optimal oral health.
Please fill out this form completely. The better we communicate, the better we can care for you.

About You

Today's Date _____

Name: _____
Last First Mi

I prefer to be called:_____

☐ Male ☐ Female Birthdate: _____/_____/_____ Age:_____

SS#:_____

Address:_____
Apt. #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced / Separated ☐ Partnered

HM #: (_____)-_____-_____ Cell/Other #: (_____)-_____-_____

How would you like to be reminded of your appointment?

(please circle**) Home, Work, Cell or Text Message**

WK #: (_____)-_____-_____ Ext:_____ DL #:_____

Employer:_____

Employer's Address: _____

_____
City State Zip

How Long There? _____ Occupation: _____

Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous / Present Dentist: _____
(Circle One)

Person Responsible for Account: _____

Insurance

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #:(__)_____

Group # (Plan or Policy #):_____

Insured's Name:_____

Relationship:_____ Birthdate:_____/_____/_____

ID #:_____ Employer:_____

Employer Address:_____

_____
City State Zip

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name:_____

Insurance Co. Address:_____

_____
City State Zip

Insurance Co. Phone #: (__)_____

Group # (Plan or Policy #):_____

Insured's Name:_____

Relationship:_____ Birthdate:_____/_____/_____

ID #:_____ Employer:_____

Employer Address:_____

_____
City State Zip

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's name:_____

Phone #:(__)_____ Date of Last Visit:____/____/_____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

Have you or do you now smoke or use tobacco in any form?

Please explain:_____ ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Phen– Fen?

(Also know as Redux or Pondimin?) ☐ Yes ☐ No

Have you ever taken Bisphosphonates? ☐ Yes ☐ No

For Women:

Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # :_____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases/medical problems?

Y N Acid Reflux
Y N AIDS/HIV positive
Y N Alcohol/Drug Abuse
Y N Anaphylaxis
Y N Anemia
Y N Arthritis, Rheumatism
Y N Artificial heart valves
Y N Artificial joints
Y N Asthma
Y N Atopic (Allergy prone)
Y N Back problems
Y N Blood Transfusion
Y N Blood Disease
Y N Cancer
Y N Chemotherapy/Radiation
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Frequent Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack / Surgery
Y N Heart Murmur
Y N Hepatitis (A) (B) (C)
Y N Herpes / Fever Blisters
Y N High Blood Pressure
Y N Hospitalized for any reason
Y N Kidney Problems
Y N Liver Disease
Y N Lupus
Y N Low Blood Pressure
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Are you allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry/Metals
Y N Latex
Y N Penicillin
Y N Tetracycline
Y N Other

Dental History

What brings you to the dentist today? _____

_____

When was your last dental visit? _____

Are you currently in pain? ☐ Yes ☐ No

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

☐ Yes ☐ No Sensitivity to cold / hot

☐ Yes ☐ No Sensitivity to sweets

☐ Yes ☐ No Sensitivity when biting

☐ Yes ☐ No Do you have pain or clicking/popping jaw

☐ Yes ☐ No Grinding or Clenching teeth

☐ Yes ☐ No Bleeding Gums

☐ Yes ☐ No Gum disease/ Treatment

☐ Yes ☐ No Food collection between teeth

How often do you brush? _____

Would you like fresher breath, whiter teeth? _____

Do you Floss Daily? ☐ Yes ☐ No

How do you feel about the appearance of your teeth? _____

_____

If you could change anything what would you change? _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

Office Use Only

I verbally reviewed the medical / dental information with the patient named herein.

Initials: _____ Date: _____

Doctors comments: _____

_____

_____

_____

_____