



DENTALILLUSIONS

**George E. Saliba DDS
Basil M. Moukarim DDS
13303 Champion Forest Drive, Building #5
Houston, Texas 77069
281.444.1755 • Fax 281.444.1314
*www.dentalillusions.com***

Patient Information

Today's Date: _____

Patient Name: _____ Preferred Name: _____
Last First MI

Male Female Married Single Child Other

Social Security #: _____ TDL# _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell: _____

Birth Date: _____ E-Mail Address: _____

Home Address: _____
Street City/State Zip Code

Work Address: _____
Street City/State Zip Code

Employer Name: _____ Position: _____ How long there?: _____

Please list other members of your immediate family who are patients in our office: _____

Referral Information

Can we thank someone for referring you?

Family Member _____

Coworker _____

Friend _____

Doctor _____

Or did you find us on your own?

___ Our Website

___ Yellow Pages

___ Lumineer or Invisalign Referral

___ Insurance Company

___ Location

___ Letter in Mail

___ Other _____

What is the reason for your visit today? _____

Date of Last Dental Visit: _____

Why did you leave your previous dentist? _____

Do you prefer to see a particular doctor in our practice? _____

Do you prefer Nitrous Oxide (laughing gas) during dental procedures? Yes No

Are you interested in sedation dentistry? Yes No

Are you interested in whitening your teeth? Yes No

If you could change your smile, what would you do? _____

Dental History

Do your jaw joints make popping, clicking, or gritty sounds? Yes No

Do you have frequent headaches or migraine headaches? Yes No

How often do you awaken with head or jaw pain of unknown origin? _____

Do you have concerns about snoring? Yes No

Do you brush and floss on a routine basis? Yes No Discuss _____

Do you think you have active decay or gum disease? Yes No

Do your gums ever bleed? Yes No Discuss _____

Do you ever have a bad taste in your mouth? _____

Are you concerned about bad breath/Halitosis? _____

Does food catch between your teeth? Any loose teeth? _____

Do you want to keep your remaining teeth? _____

Do you currently use tobacco? Yes No If so, how long? _____

Have you ever had any complications or allergic reactions following dental treatment? Yes No

If yes, please explain: _____

We routinely use latex products for your safety. If you have a known sensitivity to latex products, please notify us prior to being called back to the treatment room.

Medical History

Are you under a physician's care now? Why? _____ Who? _____ Phone _____ Yes No

Have you ever been hospitalized or had a major operation? Discuss _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss _____ Yes No

Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What? _____ Yes No

Are you on a special diet? Discuss _____ Yes No

Are you allergic to any medications or substances? Please check box below _____ Yes No

Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other _____

(Women Please Check) Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss _____ Yes No

Do you now have or have ever had nay of the following? Do you take any of these medicines? Please check appropriate boxes.

*If yes to any of the starred conditions, please call prior to your appointment... premedication or changes in medication may be required.

	Yes	No		Yes	No		Yes	No		Yes	No			
Heart Disease/Surgery *	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur or Defect *	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Bisphosphonates *	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Methemoglobinemia	<input type="checkbox"/>	<input type="checkbox"/>	Osteonecrosis of Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Renal Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Aredia I.V. Reclast I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Disorder *	<input type="checkbox"/>	<input type="checkbox"/>	Recent Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	Zometa I.V.	<input type="checkbox"/>	<input type="checkbox"/>	Parathyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse *	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Fosamaz, Actonel, Boniva *	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever *	<input type="checkbox"/>	<input type="checkbox"/>	Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Jaw Joints	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve *	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Cortisone Medicine	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Heart Pace Maker *	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint *	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary Shunt *	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Medicines)	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Allergies (Pollen/Dust)	<input type="checkbox"/>	<input type="checkbox"/>
Bacterial Endocarditis *	<input type="checkbox"/>	<input type="checkbox"/>	Bloody Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained Fever	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A (Infectious)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction/Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Need Premedication?	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily/Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>	Tattoos/Body Piercing	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken fen-phen? *	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Protease Inhibitor	<input type="checkbox"/>	<input type="checkbox"/>				Cochlear implants?	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Stent *	<input type="checkbox"/>	<input type="checkbox"/>	X-Ray Treatments (Radiation)	<input type="checkbox"/>	<input type="checkbox"/>									

Have you ever had any other serious illness not checked above? Discuss _____ Yes No

Do you wish to talk to the dentist privately about any problem? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date _____
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor _____ Date _____ BP _____ Pulse _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	PULSE	REVIEWED BY
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____
_____	_____	None <input type="checkbox"/>	_____	_____	_____	Dr. _____

Dental Illusions
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Tina Hart

Telephone: 281-444-1755 Fax: 281-444-1314

E-mail: tina@dentalillusions.com

Address: 13303 Champion Forest Drive, building #5, Houston, TX 77069

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCACTION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Social Security # _____ Group # _____

Insured's Employer Name _____

Patient's relationship to insured: Self Spouse Child Other _____

Dental insurance company name: _____

*Please read and sign to have our office file you insurance: I authorize the release of information and understand that I am responsible for all cost of dental treatments. I hereby authorize payment directly to the below-name dentist of the group insurance benefits otherwise payable to me.

Signature of patient, parent or guardian Date: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability but the patient agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient _____

AUTHORIZATION & RELEASE

PAYMENT OPTIONS

PLEASE CHOOSE ONE:

I will be paying my **estimated co-pay and any applicable deductible only** at the time of treatment and my credit card number will be kept on file. I hereby authorize Dental Illusions to keep my signature on file and to charge my credit card account for any and all treatment fees remaining after my insurance carrier has processed my claim, or any balance still remaining after 60 days. Dental Illusions agrees to make every reasonable effort to advise me before this transaction is made.

Cardholder's Signature

Cardholder's Address (street)

Cardholder's Address (city, state and zip code)

Cardholder's Telephone #

MasterCard Visa AMEX Discover

Credit Card Account # (CV Code) _____

Exp Date

OR

I will be paying in full at time of service by one of the following: CASH, CHECK, CREDIT CARD, or 3rd Party Financing (please circle one). **Dental Illusions will file my insurance claim on my behalf and will request that the benefits be REIMBURSED TO ME DIRECTLY FROM MY INSURANCE COMPANY.**

AUTHORIZATION & RELEASE: I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist (if my insurance will allow it) or dental group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I authorize my personal payment information (checks or credit cards used to make payments on your account), to be kept on file, if needed, to make restitution on any balance over 60 days past due.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian Date: _____ Relationship to Patient: _____

DENTAL ILLUSIONS

GEORGE SALIBA, D.D.S.
BASIL MOUKARIM, D.D.S.

13303 Champion Forest Dr. #5
Houston, TX 77069
Tel. (281)444-1755
Fax (281)444-1314

Consent Form

I, _____, voluntarily request Dr. George E. Saliba/Dr. Basil M. Moukarim as the dentist, and such associates, assistants and other health care providers as he may deem necessary to treat condition(s) as they relate to my hygiene care, to which I agree. I understand that each procedure will be fully explained to me and that additional treatment to be agreed upon in the future will be outlined on the treatment plan portion of my dental record.

I understand that my dentist may discover other or different conditions that may require additional or different procedures than those planned. I authorize my dentist and such associates, assistants, and other health care providers to perform such procedures that are advisable in their professional judgment.

I understand there may be other problems associated with my oral condition that may be addressed at a later date.

I understand that no warranty or guarantee has been made to me as to result, cure, or longevity of dental work.

I also give my consent for the taking of pictures, cast models, or any other dental documentation and allow the use of such pictures, casts, and models or other dental documentation by Dr. George E. Saliba/Dr. Basil M. Moukarim or their associates, in their lectures, teaching activities, or articles for publication.

I fully understand that if I utilize insurance, I am responsible for any and all fees the insurance does not cover, including any and all fees to collect should the account be turned over for collection. I also authorize Dr. George E. Saliba/Dr. Basil M. Moukarim to release any dental information or models that my insurance company deems necessary for the determination of this claim.

I certify this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

Date: _____

Signature: _____

DENTAL ILLUSIONS

GEORGE SALIBA, D.D.S.
BASIL MOUKARIM, D.D.S.

13303 Champion Forest Dr.
#5
Houston, TX 77069
Tel. (281)444-1755
Fax (281)444-1314

HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of your practice.

I have also been informed of, and given the right to view and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20__

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____