LIMBERAKIS
FAMILY DENTISTRY

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We know you have a choice who provides for your care and well-being, and we're happy you chose us! Since 1980, the Limberakis name has stood for dental excellence, compassionate treatment, and a relaxed environment in the greater Montgomery County area. We thank you for the opportunity to care for your smile and treat you like family! Please take the time to carefully fill out the information below so we can learn how to serve you best.

Patient Information

Patient Name: (Last)_____ (First)_____ (MI)_____

Address: (Street/Apt)_____ (City)_____ (Zip)_____

Birth Date: _____ Sex: _____ Age:_____ Marital Status: Minor ( ) Single ( ) Married ( )

SS#: _____ Student? Y ( ) N ( ) _____ Separated ( ) Divorced ( ) Widowed ( )

Phone #: (Home)_____ (Office #)_____

Cell #: _____ Would you like to receive texts to confirm appointments? Y ( ) N ( )

E-Mail Address: _____ Confirm appointments with e-mail? Y ( ) N ( )

Driver's License #: _____

Are any of your family members our patients? (Yes/No), if yes, who? _____

Emergency Contact _____ Emergency Contact #_____

Whom may we thank for referring you? _____

Previous Dentist's Name and phone #: _____

Approximate date of last dental visit? _____ Did you have a full series of x-rays? Y ( ) N ( )

Primary Dental Insurance

Name of Insurance Co: _____ Phone #:_____

Subscriber's Name:_____ Date of Birth:_____ Relationship?_____

Employer's Name:_____ SS#/ ID #:_____

Employer's Address:_____ Group #:_____

Secondary Dental Insurance

Name of Insurance Co: _____ Phone #:_____

Subscriber's Name:_____ Date of Birth:)_____ Relationship?_____

Employer's Name:_____ SS#/ ID #:_____

Employer's Address:_____ Group #:_____

Health History

Accurate answers to the following questions will allow us to treat you on a more individual basis, providing the care appropriate for your particular needs.

Physician's Name: _____ Phone #_____

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Stroke
- ❑ Heart Attack
- ❑ Heart ailment or angina
- ❑ Congenital heart defect (unrepaired)
- ❑ Artificial joint or heart valve replacement
- ❑ Endocarditis
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Thyroid Disease
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Arthritis
- ❑ Psychological condition _____
- ❑ Herpes or cold sores
- ❑ HPV
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Chronic Sinus Problems
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you **allergic** to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Food Allergies_____
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Chemotherapy (past or present)
- ❑ Osteoporosis (bone density) medicine (have taken past or present)

_____

List all current Medications: _____

_____

Women Only:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives
- ❑ Are you nursing?

Has your physician ever told you to take antibiotics prior to dental visits? If so, why? _____

Have you been admitted to the hospital within the last two years? For What?

_____

Any additional medical issues we should be aware of?

_____

Dental Specific

- ❒ Are you currently having dental pain?
- ❒ Do your gums bleed when you brush?
- ❒ Have you ever had orthodontic treatment or worn braces?
- ❒ Do you clench or grind your teeth?
- ❒ Do you ever wake up from sleep short of breath?
- ❒ Have you ever been diagnosed with sleep apnea?

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. I have answered the above questions accurately. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners.

X_____ Date:_____

Signature of Patient, Parent, or Guardian

Limberakis Family Dentistry

Dental Office Informed Consent

It is important to us that you fully understand the treatment we are recommending and allow us to perform. We want to involve you in all decisions concerning any invasive (under the gum line and/or soft tissues) procedures you may need. We take informed consent very seriously in our office. Therefore, this form should be signed by you only when you understand that there is risk associated with dental procedures, and that all your questions have been answered. Dental treatment is not to be taken for granted as being routine or without risk for complications. As with all medical treatment, including dental treatment, there are no guarantees that the results will be as planned and to each individual's satisfaction. When dealing with the human body there are potential variables which may or may not be predictable. Complication rates in dentistry are low but do exist. Even a minor procedure, like a "filling", can lead to an unforeseen complication. For example, a routine "Novocain" injection could lead to an allergic reaction, anaphylaxis, facial hemorrhage, swelling, bruising, and even hospitalization or death. Granted these are exceedingly uncommon, individuals who are about to have dental treatment should be made aware of this prior to consenting. For example, whenever tooth preparation or drilling is involved, the decay could lead to pulpal (nerve) exposure, fractured tooth, and/or post treatment pain to biting and to thermal sensitivity. Most post-operative discomfort is transient, but some may persist and necessitate further treatment. The above examples are possible complications with dental treatment.

I have read, understand and consent to dental treatment:

INITIAL _____ DATE_____

APPOINTMENT CANCELLATION POLICY

When you make an appointment, we reserve that time for you and we do our utmost to be on schedule. Last minute cancellations and missed appointments prevent other patients from appointing who are seeking prompt care. If necessary, please provide our office at least 24 hours to reschedule in advance of your scheduled office visit to or a $40 fee will be charged. While our office confirms appointments by telephone, text or emails two days prior to your appointment, confirmation reminders are made as a courtesy only.

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of this Notice of Privacy Practice's and to make changes regarding all protected health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by personal representative of patient):_____

Patients without Insurance:

Patients without insurance coverage are asked to pay for services when rendered. We accept Cash, Check, MasterCard, Visa, Discover, America Express or Debit/ATM cards. We also arrange pre-payments and financing plans.

Consent for Dental Photography

❒ In connection with dental treatment, which I am receiving from Limberakis Family Dentistry, I agree and consent to allow the photographs taken before, during, and after completion of my treatment to be used for dental records, communication with the dental lab, referring dentists, and specialists.

Signature:_____Date:_____

❒ I further agree and consent that the photographs relating to my dental care may be published, either separately or in connection with each other in professional journals, dental books, dental photo albums, digital media or patient counseling.

Signature:_____Date:_____

We take this opportunity to welcome you to our practice and assure you that we will do our utmost to provide you with the best care possible.