Mohamed Ahmed, DDS
(410) 729-0390
677 Old Mill Road
Millersville, MD 21108

Date____________________

PATIENT INFORMATION

Name____ SS# ______________________________
Last Name First Name Initial
E-mail Address____ Cell Phone __________________________
Address ____ Home Phone__________________________
City ____________________________________State ____________________ Zip ________________________
Sex: ☐ M ☐ F Age_________ Birthday________________ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Patient Employed By _________________________________Occupation ________________________________
Business Phone _____________________________ Who may we thank for referring you? ____________________
In Case of emergency who should be notified ___________________________ Phone __________________________

PRIMARY INSURANCE

Person Responsible for Account ____
Last First Initial
Relation to Patient ___________________________Birthday____________________SS#_______________________
Address (If different from patients) ___________________________________ Phone ____________________
City____________________________________State_______________________ Zip ________________________
Person Responsible Employed by_________________________________Occupation_________________________
Insurance Company ____
Contract # _____________________Group #_______________________Subscribers #_______________________

MEDICAL HISTORY

Have you had any serious illnesses or operations?_____________________________ If yes, Describe_______________________
Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates ______________________
(Woman) Are you pregnant? ☐ Yes ☐ No Nursing? ☐Yes ☐No Taking Birth Control? ☐Yes ☐No

Check **YES** or **NO** if you have or had any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Cortisone Treatment	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis Rheumatism	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Skin Rash
☐	☐	Artificial Joints	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Swelling of feet or ankle
☐	☐	Back Problems	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Ulcer
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever	☐	☐	Venereal Disease

Medication

List all medications you are currently taking: ______________________
____
Pharmacy Name ____
Phone ____

Allergies

☐ Aspirin ☐ Penicillin
☐ Barbiturates ☐ Sulfa
☐ Codeine ☐ Latex ______________________
☐ Local Anesthetic ☐ Other ______________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependents) have insurance coverage by ___________________________ and assigned directly to
Name of Insurance Company
Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered, I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of signature on all insurance submissions. The above information is accurate to the best of my knowledge. I will not hold my dentist or any other member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (if not patient) ___________________________________ Date____________________________

Patient's Signature ____ Date ____________________________

Doctor's Signature ____ Date ____________________________