Sunbeam Dental, LLC
Dr. John Mamoun, DMD, FAGD
100 Craig Road, Suite 106
Manalapan, NJ 07726
(732) 431-2888

Authorization to Submit Claims to Insurance Companies and Assignment of Benefits:

I hereby authorize the above named dentist(s) to provide each respective insurance company(s), claim administrator(s), and consulting health care professionals information concerning health care, advice, treatment, or supplies provided. I further authorize release of any information relating to my claim submitted on my behalf. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. If contractually permitted by my master contract, I hereby authorize payment directly to the above named dentist(s) of the dental benefits otherwise payable to me.

_____ _____
Patient or Authorized Guardian's Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgement

I acknowledge receipt of this office's Notice of Privacy Practices.

_____ _____
Signature Date

Patient Registration and Medical History

Please complete this form. If you have dental insurance, please provide your insurance information or card for photocopying. This will allow us to file a claim on your behalf.

Patient Name: _____Date of Birth: ___/____/_____
Patient SS#: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Home Telephone: ( ) _____ Work Telephone: ( ) _____

Dental insurance information (please skip if you do not have dental insurance):

Insurance Company Name: _____Title of Policy: _____
Insurance Identification #: _____ Group #: _____

Relationship to Insured (circle): Self / Spouse / Son / Daughter / Other _____
(If not "self," please provide information about the policy holder):

Policy Holder Name: _____ SS#: _____
Address: _____
City: _____ State: ____ Zip Code: _____
Telephone: ( ) _____

Medical Health History:

	YES	NO
Are you under a physician's care now? If yes, why?		
Are you taking any medications, pills, or drugs? If yes, please list here:		
Do you smoke, use chewing tobacco or snuff?		
If female, are you Pregnant/Trying to get pregnant, or nursing?		
If you cut yourself, does it bleed for a long time?		

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Other

Do you have any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failue	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/Intestine Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsilitus
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Do you have any comments on your health? _____
_____
_____
_____

Dental History:

Do you have a specific concern/s about your teeth or mouth? YES / NO
_____
_____
_____

How long since your last dental visit? _____ Last full mouth x-rays? _____

	YES	NO
Do your gums bleed or feel tender or irritated?		
Do you clench or grind your teeth?		
Do you have trouble opening or closing your jaw, or have sore jaw muscles on waking?		
Do you have difficulty chewing your food?		
Do you wear dentures? If so, circle if partials / full dentures / upper / lower / both.		
Do you use dental floss daily?		
Do you have any of the following concerns? (circle) tooth pain / mouth sores / discolored teeth / poor denture fit or retention / tooth sensitivity		
Do you know what plaque looks like?		

Consent to Initial Examination:

To the best of my knowledge, the above questions have been answered accurately. I hereby consent to the initial examination, including the taking of diagnostic radiographs (x-rays), photographs or casts as deemed necessary for optimal treatment planning.

_____ _____
Signature of Patient or Guardian Date

For Dentist Use:

Comments:_____
_____
_____

Vital signs: Blood Pressure: _____/_____ Pulse Rate: _____
Medical Info obtained from: _____ Reviewed by: _____ Date: ___/___/___

Patient name: ________________________________

Date	Tooth #	Treatment	Signature	Cha.	Pay	Bal.