PATIENT INFORMATION

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HOW WOULD YOU LIKE US TO ADDRESS YOU?

PATIENT'S NAME____
LAST, FIRST MIDDLE INITIAL

ADDRESS____

CITY/STATE/ZIP____

HOME PHONE ( ) ______________CELL PHONE ( ) ________________________________

E-MAIL ADDRESS: ____________________________SS#________________________________

HOW MAY WE CONTACT YOU? HOME PHONE: YES NO CELL: YES NO TEXT: YES NO
WORK PHONE: YES NO EMAIL: YES NO WHICH IS BEST?________________

DRIVER'S LICENSE#____________ STATE___ BIRTHDATE__________SEX______________

IF CHILD/ PARENT'S NAME____
LAST FIRST MIDDLE INITIAL

PARENTS'S: SS#_________________________BIRTHDATE_______________________
DRIVER'S LICENSE #____

EMPLOYER________________________WORK PHONE ( ) ___________EXT______________
BUSINESS ADDRESS_________________________YRS. EMPLOYED______________________
INSURANCE: _______________________________MEMBER ID#_________________________

SPOUSE'S NAME____
LAST, FIRST, MIDDLE INITIAL,
SS#__________________________BIRTHDATE______________________________________
EMPLOYER________________________WORK PHONE ( ) ____________EXT____________
BUSINESS ADDRESS_________________________YRS. EMPLOYED______________________
INSURANCE: _______________________________MEMBER ID: _________________________

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BESIDE INSURANCE, WHO IS RESPONSIBLE FOR THIS ACCOUNT?
NAME____
ADDRESS________________________________PHONE ( ) __________________________
IF DIFFERENT FROM ABOVE

IN CASE OF EMERGENCY, WHO SHOULD WE NOTIFY?
NAME____________________HOME PHONE ( ) _______________CELL ( )_____________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
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COMMENTS: ____

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I AUTHORIZE RELEASE OF ANY INFORMATION FOR INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO SAMUEL WONG, DDS OF THE GROUP INSURANCE BENEFITS.

____ _____/_____/______

SIGNED (PATIENT, OR PARENT IF MINOR)

HEALTH HISTORY

PURPOSE OF THIS VISIT? ______________________________
YES NO ARE YOU IN PAIN NOW? ________________________
YES NO ARE YOU BEING TREATED BY A PHYSICIAN NOW?
FOR WHAT REASON?_________________________________
YES NO HAVE YOU BEEN HOSPITALIZED OR HAD A SERIOUS ILLNESS?
PLEASE EXPLAIN?__________________________________

DATE OF LAST DENTAL VISIT?____________________
PREVIOUS DENTIST'S NAME______________________
DENTIST'S PHONE#_____________________________
DATE LAST MEDICAL EXAM?_____________________
PHYSICIANS'S NAME____________________________
PHONE#_______________KAISER#_______________

DO YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING

YES NO HEART CONDITION
YES NO CHEST PAIN OR ANGINA
YES NO HEART ATTACK, HEART DEFECT
YES NO RHEUMATIC FEVER
YES NO HEART MURMUR
YES NO HEART SURGERY (VALVE, BYPASS, OTHER)
YES NO HIGH BLOOD PRESSURE
YES NO STROKE
YES NO TB, EMPHYSEMA, ASTHMA OTHER LUNG DISEASE
YES NO HEPATITIS, OTHER LIVER DISEASE
YES NO PROLONGED BLEEDING FOLLOWING INJURY/SURGERY
YES NO FAINTING, CONVULSIONS, EPILEPSY
YES NO NERVOUS BREAKDOWN OR EMOTIONAL PROBLEMS
YES NO EVER TAKEN PHEN-FEN
YES NO EVER TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS
YES NO DO YOU HAVE SNORING OR SLEEP APNEA PROBLEMS

YES NO ARTHRITIS
YES NO ORAL HERPES
YES NO VENEREAL DISEASE
YES NO AIDS, HIV
YES NO DIABETES
YES NO KIDNEY DISEASE
YES NO EYE PROBLEM, GLAUCOMA
YES NO CANCER OR TUMOR
YES NO JOINT SURGERY (HIP, KNEE, OTHER)
YES NO ANEMIA
YES NO RADIATION TREATMENT
YES NO DO YOU USE TOBACCO IN ANY FORM?
YES NO ARE YOU TAKING ANY MEDICATIONS OR DRUGS NOW?
PLEASE LIST: ___________________________
____
____
____
____

HAVE YOU BECOME SICK FROM, ALLERGIC TO, OR BEEN TOLD NOT TO USE ANY OF THE FOLLOWING

YES NO PENICILLIN
YES NO OTHER ANTIBIOTICS
YES NO ASPIRIN
YES NO LATEX

YES NO CODIENE OR OTHER PAIN MEDICATIONS
YES NO NOVACAINE, XYLOCAINE OR OTHER ANESTHETICS
YES NO OTHER MEDICATIONS? ______________________

WOMEN ONLY

YES NO ARE YOU PREGNANT?
IF YES, DUE DATE?_____________
YES NO ARE YOU TAKING BIRTH CONTROL PILLS?

ALL PATIENTS

YES NO DO YOU HAVE OR HAVE HAD ANY OTHER DISEASES OR MEDICAL PROBLEMS NOT LISTED ON THIS FORM?
IF YES, PLEASE EXPLAIN__________________________

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TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGES IN MY HEALTH AND/OR MEDICATIONS.

SIGNATURE_____________________________________ DATE____/____/____ _______________
PATIENT, PARENT, OR GUARDIAN- CIRCLE ONE STAFF- INT/ DATE

HISTORY UPDATE

SIGNATURE_____________________________________ DATE____/____/______ ________________

SIGNATURE_____________________________________ DATE____/____/______ ________________

SIGNATURE_____________________________________ DATE____/____/______ ________________