WELCOME

Name: ____

I prefer to be called:______________ ☐Male☐Female

Birthdate:___/___/___ Age:____ SS# ____/____/____

HomeAddress:___________________________________

____

City State Zip

___Single ___Married___Divorced___Widowed

Home #________________Cell#_________________

Work#________________Ext_____

Employer:_____________________________________

Address:_______________________________________

How long there?__________Occupation:___________

Best time and # to reach you:___________________

Who may we thank for referring you?_____________

Other family members seen by us:

____

Previous / Present Dentist:_______________________

Last Visit Date:_________________________________

SPOUSE INFORMATION

Name:____

Birthdate:________________SS# _____/____/______

Employer:_____________________________________

WK#_________________Ext____

DENTAL INSURANCE

Insurance Co. Name:_____________________________

Address:_______________________________________

Insurance Co. Phone #:__________________________

Group# _________ Subscriber I.D. ______________

Insured's Name_________________________________

Insured's DOB __/__/__ Insured's SS#____/___/____

Today's Date:_________________

MEDICAL HISTORY

Physicians Name:________________________________

Phone # ______________Date of last visit__________

Current physical Health is: ___Good ___Fair ___Poor

Are you currently under the care of a physician:______

Please explain __________________________________

List all prescription and over the counter medications:

____

For Women Are you taking birth control pills:______

Are you pregnant?:___________ Week#___________

Are you nursing?:______________________________

Please CIRCLE any of the following diseases or medical problems that apply.

Heart Attack/Stroke	Psychiatric Problems
Cancer / Chemotherapy	Epilepsy / Seizures / Fainting
Heart Murmur	Diabetes / Tuberculosis (TB)
Rheumatic Fever	Drug / Alcohol Abuse
HIV / AIDS	Venereal Disease
Heart Surgery / Pacemaker	Hemophilia/Abnormal Bleeding
Shingles	Ulcers / Colitis
Mitral Valve Problems	Congenital Heart Disease
Kidney Problems	Anemia / Radiation Treatment
Artificial Bones / Joints	Asthma / Arthritis
Artificial Valves	Difficulty Breathing
Sinus Problems	Hospitalized for any reason
High / Low Blood Pressure	Hepatitis
Fever Blisters	Blood Transfusion
Severe / Frequent Headaches	Emphysema / Glaucoma

Please list any other medical conditions that you have had:

____

____

Are you allergic to any of the following drugs?

Y N Penicillin	Y N Tetracycline	Y N Latex
Y N Aspirin	Y N Dental Anesthetics	Y N Other
Y N Erythromycin	Y N Codeine	

Please list any other drugs allergies:_______________

Emergency Contact Person

Name:____

Phone #________________Relation:______________

DENTAL HISTORY

*Why have you come to the dentist today?

____

____

*Are you currently in pain?_______________________

*Have you ever had a serious / difficult problem associated with any previous dental work?__________

*Do you now or have ever had pain / discomfort in your jaw joint (TMJ/TMD)?_____________________

*Your current dental health is..

______Good ______Fair ______Poor

*Do your gums ever bleed? _____Yes _____No

*How many times a week do you floss?_____

*How many times a day do you brush?______

*Type of bristles? ____hard ____medium ____soft

*How long since you have seen a dentist?__________

*Last complete DENTAL EXAM, Date:______________

*Last FULL MOUTH X-RAY, Date:_________________

*Have you worn BRACES (orthodontics)?___________

*Have you had any PERIODONTAL (GUM) treatments?___________ When?__________________

*Do you wear a DENTURE or PARTIAL?_____________

*Do you use any type of tobacco product, and if so, what kind?____________________________________

It is the policy of this office to protect all of your private health information. There are, however, times when it may become necessary for us to discuss your treatment, post-operative treatment, appointments or billing with someone other than yourself. Please list the names of the individuals that we may speak with, and their relationship to you.

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE

How will this account be paid?

____Cash ____Check ____Charge: card type________

The information that I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

____

Signature of Patient / Guardian Date

I assign all insurance benefits directly to Dr Linda Huang. I authorize the dentist to release all necessary information to secure payment of insurance benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I understand that I am financially responsible for all charges. Any unpaid balance remaining is considered delinquent after 90 days from treatment and is subject to a 2% monthly maintenance fee. Should I default on payment of my account I agree to pay an additional 40% for collection agency fees and, if necessary, additional court costs and attorney fees.

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Signature of Patient / Guardian Date

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