John H. Ko, DDS

PATIENT REGISTRATION

Medical Alert

Patient Information

Last Name	First	Mid. Initial
Address		
City		Zip Code
Home Phone #	Cell Phone #	Work Phone #
Email Address		
Whom May We Thank for Referring You to Our Office?		
Date of Birth (mm/dd/yy)	Social Security #	
Driver's License #	Marital Status: (circle one) Single Married Other	
Employer	Employer Phone #	
Business Address		
City		Zip Code
Occupation		
Emergency Contact		Phone #

Spousal/Guardian Information

Last Name	First	Mid. Initial
Address (if different)		
City		Zip Code
Home Phone #	Cell Phone #	Work Phone #
Relationship to Patient		
Spouse's/Guardian's Employer		Employer Phone #
Business Address		
City		Zip Code
Occupation		

Dental Insurance Information

Primary Insurance Co.	Group #
Insured's Employer	Date of Birth (mm/dd/yy)
Insured's Name	Insured's Soc. Sec. #/ID#

Secondary Insurance Co. (if applicable)	Group #
Insured's Employer	Date of Birth (mm/dd/yy)
Insured's Name	Insured's Soc. Sec. #/ID#

Medical History

Physician's Name & Address_____ Phone # _____

Have you been treated for any of the following conditions? (Please check.)

	Yes	No		Yes	No
Heart Disease or Murmur			Infectious or Communicable Disease incl. HIV		
Rheumatic Fever			Hepatitis, Yellow Jaundice, Liver Disease		
Mitral Valve Prolapse			Endocrine Disease (e.g. Thyroid)		
High or Low Blood Pressure			Epilepsy or Other Nervous Disorders		
Diabetes			Bone, Muscle or Joint Disorders (e.g. Arthritis)		
Tuberculosis or Lung Disease			Cancer		
Kidney Disease			Radiotherapy or Chemotherapy		
Artificial Joints or Valves			Antibiotic Pre-medication Required?		

Please Complete Reverse Side

Please circle Yes or No for the following questions;

Yes No Are you under a physician's care at present? If yes, why? _____

Yes No Have you ever been a patient in a hospital, undergone any surgery or suffered any major illnesses? If yes, indicate year of hospitalization and reason _____

Yes No Are you taking any medication, prescription or non-prescription of any kind? If yes, please name these drugs, their dosage and frequency _____

Yes No Are you allergic to any medications or latex? If yes, please name _____

Yes No Do you bleed excessively?

Yes No Do you faint easily?

Yes No Have you had any difficulties with local anesthetics? If yes, explain _____

Yes No Have you ever smoked? If yes, how much and how long? _____

Yes No For Women: Are you pregnant? If yes, what is your due date? _____

Yes No For Women: Do you take birth control medication?

Dental History

Former Dentist's Name & City_____ Phone # _____

Why did you leave your former dentist? _____

Date of last dental exam _____ Date of last complete set of X-rays _____

What is your immediate dental concern? _____

Yes No Do your gums bleed?

Yes No Would you be interested in improving the appearance of your teeth? If yes, explain _____

Yes No Do you have any oral habits such as clenching, grinding your teeth or nail biting?

If there is any information you believe would be helpful for Dr. Ko to know, please explain: _____

I certify that the information is correct to the best of my knowledge, and I will notify the dentist in case there is any change in the medical history. I understand that despite any dental insurance, I am ultimately responsible for all fees for services rendered.

Date _____ **Signature** _____ **Signature** _____
(Patient/Parent/Guardian) (Dentist)

Medical History Update

Date _____ Any changes in medical history? If yes, explain _____

Signature (Patient/Parent/Guardian)_____ Signature (Dentist)_____

Date _____ Any changes in medical history? If yes, explain _____

Signature (Patient/Parent/Guardian)_____ Signature (Dentist)_____

Date _____ Any changes in medical history? If yes, explain _____

Signature (Patient/Parent/Guardian)_____ Signature (Dentist)_____

Date _____ Any changes in medical history? If yes, explain _____

Signature (Patient/Parent/Guardian)_____ Signature (Dentist)_____