

PATIENT INFORMATION

NAME: _____

Patient Information

Date: _____

Gender: M F Married _____ Single _____ Birth Date: _____ SSN: _____

Driver's License #: _____ E-Mail Address: _____

Address: _____ Street _____ Apt. # _____

City _____ State _____ Zip Code _____

Phone #'s: Home _____ Work _____ Ext. _____ Best time to call: _____

FAX _____ Cell phone _____ Other _____

Occupation / School: _____ Employer / Grade: _____

Is another member of your family or relative a patient at our office?

Name _____ Relationship _____

Emergency Contact Information

Name: _____ Relation: _____

Home Phone #: _____ Work Phone #: _____

Insurance Information

PRIMARY:

Name of Insured: _____ Last _____ First _____ MI _____

Insured's Birth Date: _____ ID# _____ Group #: _____ Union or Local # _____

Insurance Plan Name , Address & Telephone# : _____

Insured's Employer Name: _____

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other _____

SECONDARY:

Name of Insured: _____ Last _____ First _____ MI _____

Insured's Birth Date: _____ ID# _____ Group #: _____ Union or Local # _____

Insurance Plan Name , Address & Telephone# : _____

Insured's Employer Name: _____

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other _____

Consent for Treatment

1. I hereby authorize doctor and designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnostic of my dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. For Women Only: I fully understand that using antibiotics reduce the effectiveness of birth control pills and should use other forms of birth control is prescribed antibiotics.

Client: _____ Date: _____

Client or Responsible Party: _____ Relationship: _____

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking (or supposed to be taking) any medication, drugs or pills now? Yes No
 If so, please list name and dose _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
 If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? Yes No
6. When you walk up stairs or take a walk do you ever have to stop because of chest pain, shortness of breath or tired feeling? Yes No
7. Indicate which of the following you have had, or have at present. **Circle "yes" or "no" to each item.**

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis Type _____	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	H.I.V. Positive	Yes	No
Heart Murmur	Yes	No	Emphysema	Yes	No	A.I.D.S.	Yes	No
Mitral Valve Prolapse	Yes	No	Chronic Cough	Yes	No	Cold Sores / Fever Blisters	Yes	No
Artificial Heart Valve	Yes	No	Tuberculosis	Yes	No	Blood Transfusion	Yes	No
Heart Pacemaker	Yes	No	Asthma	Yes	No	Hemophilia / Abnormal Bleeding	Yes	No
High / Low Blood Pressure.....	Yes	No	Hay Fever	Yes	No	Sickle Cell Disease	Yes	No
Stroke	Yes	No	Latex Sensitivity	Yes	No	Bruise Easily	Yes	No
Diet (Special / Restricted)	Yes	No	Allergies or Hives	Yes	No	Liver Disease	Yes	No
Rheumatic Fever	Yes	No	Sinus Trouble	Yes	No	Yellow Jaundice	Yes	No
Arthritis / Rheumatism	Yes	No	Radiation Therapy	Yes	No	Neurological Disorders	Yes	No
Cortisone Medicine	Yes	No	Chemotherapy	Yes	No	Epilepsy or Seizures	Yes	No
Swollen Ankles	Yes	No	Tumors	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.) ...	Yes	No	Glaucoma	Yes	No	Nervous / Anxious	Yes	No
Kidney Trouble	Yes	No	Contact Lenses	Yes	No	Psychiatric / Psychological Care ...	Yes	No

10. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____

11. **Women:** Are you: **Pregnant?** Yes, _____ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. (Please sign below)

Patient / Guardian Signature _____ Date _____

History Review: A.S.A. Class _____

VITAL SIGNS	Temp	Pulse	Resp	B.P.							
				Date							

Dentist Signature _____ Date _____

DENTAL HISTORY

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do You:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

Have you ever experienced: Yes No

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Are you interested in having whiter teeth, straighter teeth, replacing missing teeth or having veneers? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Notice of Privacy Practice Acknowledgements and Policies

We keep a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Benjamin An, DDS.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

Financial Agreement

All payments are due at the time of service unless other arrangements have been previously made and agreed upon by the treating doctor. Estimation of insurance payment is not a guarantee of coverage. It is the patient's responsibility to pay their balance regardless of insurance coverage. In the event payments are not received by agreed upon dates, a 5% interest charge may be added to your account. Any payments not received after 90 days of the service date will be sent to a collections agency. Third party financing is available-Please ask the office staff about this.

Cancellation Policy

Scheduled appointments are a contract between the doctor and the patient. Any appointments that are cancelled with less than 48 hours notice or a failure to arrive for a scheduled appointment may incur a fee per scheduled hour of time. Patients that need to reschedule their reserved appointment time will need to call during **office hours only**. If a message is left during weekends or times when the office is not open, that will not be considered acceptable advanced notice.

Thank you very much for taking the time to review our privacy practice, financial agreement, and cancellation policy. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledgement and receipt of our policy by signing and returning this form to the office. We look forward to being of service to you.

By my signature below I acknowledge and agree to the Notice of Privacy Practices and Office Policies.

Signature of Patient or Legal Guardian

Date

Printed name if signed on behalf of the patient

Relationship to the patient