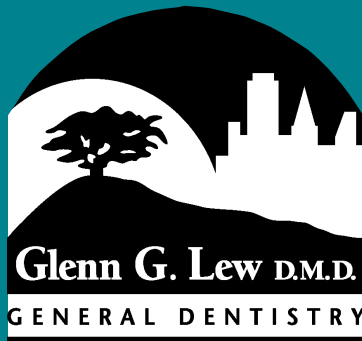


Welcome



We want to make your world a better place, with a healthy smile. Please complete this form so we can provide you with the comprehensive care you deserve. We thank you for choosing us to take care of you and your dental needs.

-Dr. Glenn Lew & Staff

1

About You

Today's Date: ___ / ___ / ___

Name: _____

I prefer to be called: _____ Male Female

Birthdate ___ / ___ / ___ SS #: _____

Home Address _____

Single Married Divorced Widowed Separated

Hm #: _____ Cell / Other # _____

Wk #: _____ Ext: _____

E-mail: _____

How would you like to be contacted:

E-mail Phone Text Postcard All

Employer:

Employer's Address: _____

How long there? _____ Occupation: _____

Best time and place to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

2

Spouse Information

His / Her Name: _____

Employer: _____

Wk #: () _____ Cell #: () _____

SS #: _____

Birthdate: ___ / ___ / ___

3

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Please give your insurance card to office staff to verify eligibility.

Insurance Co. Phone #: () _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___ / ___ / ___ Insured's SS #: _____

Insured's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Please give your insurance card to office staff to verify eligibility.

Insurance Co. Phone #: () _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___ / ___ / ___ Insured's SS #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/ Her Name: _____

Relation: _____

Wk #: () _____ Ext: _____

Hm #: () _____ Cell #: () _____

CONTINUED ON BACK

4

Medical History

Date of last health care exam: _____

What was this exam for? _____

Have you been hospitalized in the last 5 years? Yes No

If yes, reason: _____

Are you currently receiving medical care? Yes No

If yes, what for? _____

List physicians & phone numbers who are currently providing care for you:

For women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No

If no, are you planning a pregnancy in the near future? Yes No

Are you nursing? Yes No

Have you ever taken any biophosphonates (Fosamax®, Aredia®, Zometa®, Actonel®, or Boniva®)? Yes No

Have you ever had any of the following diseases or medical problems:

- | | |
|---|--|
| <input type="checkbox"/> Anemia or Blood Disorder | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Angina Pectoris | Your normal BP _____/_____ |
| <input type="checkbox"/> Arthritis, Rheumatism, or any other inflammatory disease. | <input type="checkbox"/> HIV / AIDS or ARC |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Abnormal bleeding from a cut | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Cancer or tumor | When placed _____ |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Do you take insulin? | <input type="checkbox"/> Liver Disease including jaundice |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Sore/Enlarged Lymph Nodes |
| <input type="checkbox"/> Emphysema or other respiratory/lung illnesses | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Previous Biopsies |
| <input type="checkbox"/> Frequent Headaches <input type="checkbox"/> Migraines | <input type="checkbox"/> Radiation or Chemotherapy Treatment |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Abnormal Heart or Previous Bacterial Endocarditis | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart Valve (artificial) or Heart Transplant | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> Slow Healing Mouth Sores |
| <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Snoring or <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Heart Stent When placed _____ | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Herpes / Fever blister | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Venereal Disease |
| | <input type="checkbox"/> Other Conditions _____ |
| | <input type="checkbox"/> Recurrent Illnesses |

Do you use tobacco? Smoke Chew None

How many times per day? _____

If you smoke, would you like to quit? Yes No

Do you consume alcohol? Yes No

Approximately how many alcoholic beverages per week? _____

Do you use any mood altering drugs? Yes No Type: _____

5

Medication History

List all the prescribed or over the counter medications that you take presently:

- _____
- _____
- _____
- _____

Are you taking any of these medications?

- | | |
|--|--|
| <input type="checkbox"/> Premedication before dental visit | <input type="checkbox"/> Tagamet ®(cimetidine) |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Prilosec ®(omeprazole) |
| <input type="checkbox"/> Dilantin or Tegretol ® | <input type="checkbox"/> Cardizem® (diltiazem) |
| <input type="checkbox"/> Barbiturates (any) | <input type="checkbox"/> Calan, Isoptin® (Verapamil) |
| <input type="checkbox"/> St. John's Wort or Kava-Kava | <input type="checkbox"/> Diflucan® (fluconazole) |
| <input type="checkbox"/> Biaxin® (clarithromycin) | <input type="checkbox"/> Sporonox® (itraconazole) |
| <input type="checkbox"/> Herbal medications | Type: _____ |

Have you ever taken any prescription drugs such as fen-phen for weight loss? Yes Dates of use: _____

Do you consume grapefruit juice, grapefruits or grapefruit extract? Yes No

Are you allergic or have you had a reaction to:

- | | |
|---|--|
| <input type="checkbox"/> Local anesthetics | <input type="checkbox"/> Codiene, Valium, or other sedatives |
| <input type="checkbox"/> Penicillin or other antibiotic | <input type="checkbox"/> Latex <input type="checkbox"/> Metals |
| <input type="checkbox"/> Apirin, Ibuprofen, or Tylenol | <input type="checkbox"/> Others _____ |

6

Dental History

Why have you come to the dentist today? _____

Previous dentist name: _____ Date of last dental visit: ___/___/___

Do you like the way your teeth look? Yes No

Describe the condition of your teeth and gums? Good Fair Poor

Are your teeth sensitive to? Hot Cold Pressure Sweets

Are you currently having pain or discomfort with your teeth or gums? Yes No

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

Do your gums bleed when you brush? Yes No Floss? Yes No

Have you ever experienced pain in your jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

Do you grind or clench your teeth? Yes No

Do you have any fear of dental treatment? Yes No

Would you like to try any of the following? Nitrous gas Conscious sedation

I understand that the information is correct to the best of my knowledge. I understand it 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 Dr. Lew and his the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or his staff to use any photos he may take to be used for lecturing, publishing, or education purposes.

signature _____ date _____