

PATIENT'S NAME: First _____ M.I. _____ Last _____ Date ____/____/____

Soc. Sec. # _____ Birthdate _____ Sex _____ Referred By _____

GUARANTOR INFORMATION (Person Responsible For Bill) (If Minor – Custodial Parent or Guardian)

Name _____ Soc. Sec. # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ E-Mail _____

Home Phone _____ Work Phone _____

Occupation _____ Employer _____

Spouse's Name _____ Soc. Sec. # _____ Birthdate _____

Spouse's Occupation _____ Employer Phone _____

In Case of Emergency Contact: Name: _____ Phone _____

INSURANCE INFORMATION

1. Subscriber Name _____ ID # _____

Employer Insurance Company _____ Phone _____ Group # _____

2. Medical Ins. _____ Phone _____ ID # _____

Employer Insurance Company _____ Group # _____

SIGNATURE _____

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for claims.

MEDICAL/ INFORMATION

Physician _____ Last Treated _____

Phone _____

	NO	YES		NO	YES
Rheumatic fever _____	_____	_____	Epilepsy _____	_____	_____
Heart murmur _____	_____	_____	Emphysema _____	_____	_____
Mitral valve prolapse _____	_____	_____	Sexually transmitted disease _____	_____	_____
Heart Attack _____	_____	_____	HIV, AIDS or other communicable diseases _____	_____	_____
Angina/chest pains _____	_____	_____	Asthma _____	_____	_____
Congestive heart failure _____	_____	_____	Seasonal allergy, sinus problems _____	_____	_____
High or low blood pressure _____	_____	_____	Have you ever used Fen/Fen or Redux? _____	_____	_____
Stroke _____	_____	_____	Have you had an EKG? _____	_____	_____
Shortness of breath, ankle swelling _____	_____	_____	Substance abuse/alcoholism _____	_____	_____
Hepatitis A, B, C, or carrier _____	_____	_____	Do you smoke? How much? _____ How long? _____	_____	_____
Jaundice or liver disease _____	_____	_____	Do you chew tobacco? How long? _____	_____	_____
Clotting problems _____	_____	_____	Have you been hospitalized? _____	_____	_____
Anemia/bruise easily _____	_____	_____	Do you take any medications? _____	_____	_____
Stomach or duodenal ulcers _____	_____	_____	Drug allergy or reaction? _____	_____	_____
Kidney disease, infection and/or dialysis _____	_____	_____	Skin reaction to jewelry _____	_____	_____
Cancer _____	_____	_____	Latex allergy _____	_____	_____
Diabetes _____	_____	_____	Do you have any diseases or conditions not listed? _____	_____	_____
Immune disease _____	_____	_____			
Organ transplants _____	_____	_____	WOMEN ONLY		
Artificial joints _____	_____	_____	Are you pregnant? Due Date _____	_____	_____
Tuberculosis _____	_____	_____	Hormone replacement therapy? _____	_____	_____
			Are you taking birth control pills? _____	_____	_____

OFFICE USE ONLY

PREMED:
 YES NO

CONSENT: I understand the above information is necessary to provide me with dental care in a safe and efficient manner. The information on this page and the medical history are correct to the best of my knowledge. DAVID K. CHAN, D.M.D., P.S. wants you to be fully informed about any proposed treatment, the risks and consequences thereof, and any alternatives. By your signature below, you request that DAVID K. CHAN, D.M.D., P.S. provide general dental care and treatment to the patient listed above. You should be aware that dental procedures, including anaesthesia, may involve risk of temporary or permanent injury or even death. Non-treatment of tooth or gum disease may result in progressive damage to the teeth, mouth and gums.

PATIENT SIGNATURE _____ Date _____

DENTAL HISTORY

Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES NO**

Personal History

1. Are you fearful of dental treatment? Scale of 1 to 10 (very) _____
2. Have you had an unfavorable dental experience?.....
3. Have you ever had complications from past dental treatment?.....
4. Have you ever had trouble getting numb or reactions to local anesthetic?.....
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?.....
6. Have you had any teeth removed?.....

Smile Characteristics

7. Is there anything about the appearance of your teeth that you would like to change?.....
8. Have you ever whitened (bleached) your teeth?.....
9. Are you self conscious about your teeth?.....
10. Have you been disappointed with the appearance of previous dental work?.....

Bite and Jaw Joint

11. Do you / would you have any problems chewing gum?
12. Do you / would you have any problems chewing bagels or other hard foods?.....
13. Have your teeth changed in the last 5 years, become shorter, thinner or worn?.....
14. Are your teeth crowding or developing spaces?.....
15. Do you have more than one bite or do you clench (squeeze) to make your teeth fit together?.....
16. Do you have any problems with sleep or wake up with an awareness of your teeth?.....
17. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping).....
18. Do you have tension headaches or sore teeth?.....
19. Do you wear or have you ever worn a bite appliance?.....

Tooth Structure

20. Have you had any cavities within the past 3 years?.....
21. Do you have a dry mouth?.....
22. Are any teeth sensitive to hot, cold, biting or sweets?.....
23. Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?.....
24. Do you avoid brushing any part of your mouth?.....

Gum and Bone

25. Have you ever been diagnosed or treated for periodontal (gum) disease?.....
26. Have you ever experienced gum recession?.....
27. Is there anyone with a history of periodontal disease in your family?.....
28. Do your gums bleed when brushing, flossing or eating?.....
29. Are your teeth becoming loose?.....
30. Have you ever noticed an unpleasant taste or odor in your mouth?.....
31. Have you experienced a burning sensation in your mouth?.....