DENTAL REGISTRATION AND HISTORY

ALL SMILES DENTAL CARE
LARRY CAO, D.D.S
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Telephone: (916) 988-0187

PLEASE PRINT

Date_____ Home Phone_____ Cell Phone _____

PATIENT INFORMATION

Name_____ SS/Patient ID# _____
Last Name First Name MI

Address_____ E-mail _____

City _____ State _____ Zip _____ Drivers License # _____

Birthdate _____ Age _____ Sex : Male ___ Female ___ Married____ Widowed ____ Single _____ Minor ____
Separated____ Divorced _____ Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ City _____ State _____ Zip _____

Employer/School Phone _____ Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (_____) _____

PRIMARY DENTAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Social Soc. # _____

Address if different from patient's _____ Phone (_____) _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Business Phone (_____) _____

Insurance Company _____ Phone (_____) _____

Group # _____ Subscriber ID # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes _____ No _____

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address if different from patient _____ Phone (_____) _____

Subscriber Employed by _____ Business Phone (_____) _____

Insurance Company _____ Social Sec. # _____

Group # _____ Subscriber ID _____

Names of other dependents covered under this plan:

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr. Larry Cao D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please Print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

DENTAL HEALTH HISTORY
(Confidential)

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address _____ City _____ State _____ Zip _____

Check (X) if have had problems with any of the following:

_____ Bad Breath	_____ Grinding teeth	_____ Sensitivity to hot	____ Bleeding gums
_____ Loose teeth or broken fillings	_____ Sensitivity to sweets	_____Clicking or popping jaw	____ Periodontal treatment
_____ Sensitivity when biting	_____ Food collection between	_____ Sores or growths in mouth	____Sensitivity to cold

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

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lominim, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ____ Yes ____No

Have you ever had any serious illnesses or operations? ___ Yes ___No If yes, describe _____
Have you ever had a blood transfusion? _____ Yes ____ No If yes, give approximate dates_____

(Women) Are you pregnant? ____ Yes _____No Nursing? _____Yes _____No Taking birth control pills? _____Yes _____ No

Check (X) if you have or have had any of the following:

___ Anemia	___ Cortisone Treatments	____ Hepatitis	___ Scarlet Fever
___ Arthritis, Rheumatism	___ Cough, Persistent	____ High Blood Pressure	___ Shortness of Breath
___ Artificial Heart Valves	___ Cough up Blood	____ HIV/AIDS	___ Skin Rash
___ Artificial Joints	___ Diabetes	____ Jaw Pain	___ Stroke
___ Asthma	___ Epilepsy	____ Kidney Disease	___ Swelling of Feet or Ankles
___ Back Problems	___ Fainting	____ Liver Disease	___ Thyroid Problems
___ Blood Disease	___ Glaucoma	____ Mitral Valve Prolapse	___ Tobacco Habit
___ Cancer	___ Headaches	____ Pacemaker	___ Tonsillitis
___ Chemical Dependency	___ Heart Murmur	____ Radiation Treatment	___ Tuberculosis
___ Chemotherapy	___ Heart Problems	____ Respiratory Disease	___ Ulcer
___ Circulatory Problems	___ Hemophilia	____ Rheumatic Fever	___ Venereal Disease

MEDICATIONS

Are you taking MEDICATIONS? _____ Yes _____ No
List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

Are you ALLERGIC to anything? _____Yes _____No

___ Aspirin ___ Local Anesthetic ____ Codeine

___ Barbiturates (sleeping pills) ____ Penicillin ____ Sulfa

___ Iodine ____ Local Anesthetic ____ Latex

Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____