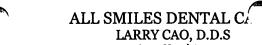
## **DENTAL REGISTRATION AND HISTORY**



LARRY CAO, D.D.S 6045 Hazel Ave Orangevale, CA 95662 Telephone: (916) 988-0187

PLEASE PRINT

Date Home Phone			Cell Phone		
	PATIEN <sup>-</sup>	T INFORMATI	ON		
Namo			SS/Patient ID#		
NameLast Name	First Name	MI	SS/Patient ID#		
			E-mail		
			Drivers License #		
Patient Employer/School	Age Sex . Ivial	e Pennale	Married Widowed Single Separated Divorced Partnered for	or years	
			State Zip		
			re thank for referring you?		
			Phone ()		
in case of emergency who should be t	- Iounca:				
PRIMARY DENTAL INSURANCE					
Person Responsible for Account					
	Last Name	First Na	me Middle Social Soc. #	Initial	
			Phone ()		
•			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		Rithdate	Relation to Patient		
Address if different from patient					
			Phone ()		
Insurance Company					
	Social Sec. # Subscriber ID				
Names of other dependents covered u					
ASSIGNMENT AND RELEASE					
I certify that I, and/or my dependent(s), have insurance coverage with and assign directly to					
<u>Dr. Larry Cao D.D.S.</u> 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 Represent	tative	Date	<del></del>	
Please Print name of Patient	t, Parent, Guardian or Personal R	Representative	Relationship to Patient	_	

## **DENTAL HEALTH HISTORY**

(Confidential)

DENTAL HISTORY					
Reason for today's visit	Date of last dental care				
Former Dentist					
	CityStateZip				
Check (X) if have had problems with any of the following:  Bad Breath Coose teeth or broken fillings Sensitivity when biting Food collection between	Sensitivity to hot Bleeding gums Clicking or popping jaw Periodontal treatment Sores or growths in mouth Sensitivity to cold				
How often do you floss? How often	How often do you brush?				
MEDICAL HISTORY					
hysician'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) YesNo					
Have you ever had any serious illnesses or operations?YesNo					
(Women) Are you pregnant?YesNo Nursing?YesNo Taking birth control pills?YesNo					
Check (X) if you have or have had any of the following: Anemia	Hepatitis Scarlet Fever High Blood Pressure Shortness of Breath HIV/AIDS Skin Rash Jaw Pain Stroke Kidney Disease Swelling of Feet or Ankles Liver Disease Thyroid Problems Mitral Valve Prolapse Pacemaker Tonsillitis Radiation Treatment Tuberculosis Respiratory Disease Ulcer Rheumatic Fever Venereal Disease				
MEDICATIONS ALLERGIES					
Are you taking MEDICATIONS? Yes No List any medications you are currently taking and the correlating diagnosis:  Pharmacy Name	Are you ALLERGIC to anything?YesNoAspirinLocal AnestheticCodeineBarbiturates (sleeping pills) Penicillin SulfaLocal AnestheticLatex  Other				
Phone ()					
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					