ROBERT L.K. WONG, D.D.S., INC.

Patient Name _____ M ____ F ____ Birthdate _____

Home Address _____ City/St _____ Zip _____

Home Phone _____ Business Phone _____ Cell _____

Social Security # _____ Occupation/School _____

Billing Name _____ Relationship _____

Billing Address _____ City/St _____ Zip _____

Primary Dental Insurance _____ Group# _____

Subscriber's Name _____ Social Security # _____

Secondary Dental Insurance _____ Group# _____

Subscriber's Name _____ Social Security # _____

Name of Physicians _____ Phone _____

Name of Previous Dentist _____ Phone _____

Referred to this office by _____

Emergency Contact Person _____

Relationship _____ Phone _____ Cell/Pager _____

When was your last visit to a dentist? _____ X-Rays _____

Have you ever been informed you need antibiotics before a dental treatment? Yes ____ No ____

Do any of these conditions apply to you?

Sore/Bleeding Gums Yes ____ No ____ Clench/Grind Teeth Yes ____ No ____

Teeth Sensitivity Yes ____ No ____ Jaw Clicking/Popping Yes ____ No ____

I hereby consent to all dental treatment and services provided by Robert L. K. Wong, DDS, Inc. I also authorize the above mentioned corporation to provide the patient's dental insurance carriers with information regarding patient's dental treatment. This information will be used for the sole purpose of evaluation and administration of benefit claims. Further, I will be responsible for any charges incurred for services rendered to above patient by said dental corporation.

_____ Date _____

Signature of Patient/Parent or Guardian

(over)

PERSONAL HEALTH HISTORY

1. Are you presently ill or under the care of a doctor? Yes ☐ No ☐
   If yes, for what are you being treated? _____
2. Have you had any serious illness or operation? Yes ☐ No ☐
   If yes, please describe (provide dates): _____
3. Do you smoke? Yes ☐ No ☐
4. Are you currently taking any medications / drugs / over-the counter drugs or dietary-herbal supplements? Yes ☐ No ☐
   If yes, please list: _____
   _____
5. Are you allergic or sensitive to any drug / latex / food / insect sting / metal? Yes ☐ No ☐
   If yes, please list: _____
6. Females: Are you or might you be pregnant? (estimated delivery date_____) Yes ☐ No ☐
   Are you taking contraceptives or hormones? Yes ☐ No ☐
   Are you breastfeeding? Yes ☐ No ☐

HAVE YOU EVER HAD OR HAVE YOU NOW ANY OF THE FOLLOWING?

(Check Each Item)	Yes	No	(Check Each Item)	Yes	No	(Check Each Item)	Yes	No
Heart Problems			Diabetes			Fainting or Dizziness		
Angina			Liver Disease			Epilepsy (Seizures)		
Heart Murmur			Hepatitis (Type:)			Sinus Trouble		
Heart Valve Problem			Stomach Ulcer			Mental Health Disorders		
Prosthetic Heart Valve			Kidney Problems			Glaucoma		
High Blood Pressure			Thyroid Disease			Cold Sores or Herpes		
Rheumatic Fever			Tuberculosis			HIV		
Heart Pacemaker			PPD Positive			Venereal Disease		
Anemia			Emphysema			Cancer		
Abnormal Bleeding			Asthma			Radiation Treatment		
Prosthetic Joint Replacement			Persistent Cough			Alcoholism		
Blood Transfusion			Stroke			Drug Addiction		

Do you have any disease, condition or problem not listed above? _____
_____

HEALTH UPDATES

Date	Comment	Initial	Date	Comment	Initial	Date	Comment	Initial