MIA M. CHUN, D.D.S.
PETER K. HAN, D.D.S.
24301 Southland Dr suite 505
Hayward, CA 94545

ACQUAINTANCE FORM

PATIENT INFORMATION – PLEASE PRINT CLEARLY

Mr ☐ Mrs.☐
Miss☐ Ms. ☐ ______________________ Date of Birth ______________

Address ______________________ Apt.# ______ City ______________ State ____ Zip ____________

Home Phone ( ) ______________ Work Phone ( ) ______________ e-mail ______________

Social Security Number ______________ Age ________ Driver's License Number ______________

Name of Physician ______________________ Physician's Phone ( ) ______________

Referred by ______________________ Occupation ______________________

Emergency Contact Name ______________________ Phone ( ) ______________

RESPONSIBLE PARTY INFORMATION IF PATIENT IS A MINOR

Name ______________________ Relationship ______________

Address ______________________ Apt.# ______ City ______________ State ____ Zip ____________

Home Phone ( ) ______________ Work Phone ( ) ______________ e-mail ______________

Social Security Number ______________ Date of Birth ________ Driver's License Number ______________

Place of Employment ______________________________________

EMPLOYER/INSURANCE INFORMATION

Employer ______________________ Employer phone ( ) ______________

Employer Address ______________________ City ______________ State ____ Zip ____________

Do you have Dental Insurance? Yes ☐ No ☐ Name of Insurance ______________________

Insurance Address ______________________ City ______________ State ____ Zip ____________

Insurance Phone ( ) ______________ Policy Number ______________ Group/Local Number ______________

Name of Insured Person First ______________ Middle ______________ Last ______________

Social Security Number ______________________ Date of Birth ______________

ARE YOU COVERED UNDER ANOTHER INSURANCE? Yes ☐ No ☐

Name of Insurance ______________ Policy Number ______________ Insurance Phone ( ) ________

Insurance Address ______________________ City ______________ State ____ Zip ____________

Name of Insured Person First ______________ Middle ______________ Last ______________

Social Security Number ______________________ Date of Birth ______________

Employer ______________________ Employer phone ( ) ______________

Employer Address ______________________ City ______________ State ____ Zip ____________

ACKNOWLEDGEMENT AND AUTHORITY

This is my consent for the dentistry indicated on the examination chart. I also agree to the use of a local anesthetic and pre-medication or sedation depending upon the judgement of the dentists involved in my case. I have been informed of all probable complications of the dentistry, anesthesia, premedication, sedation and other drugs. I also acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE, unless other arrangements are made with the office representative. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

Signed: ______________________________________ Date: ______________

PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)

HEALTH HISTORY

Patient's Name____

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1.	Yes	No	Is your general health good?
2.	Yes	No	Has there been a change in your health within the last year?
3.	Yes	No	Have you been hospitalized or had a serious illness in the last three year? Why?__________
4.	Yes	No	Are you being treated by a physician now? For what? __________ Date of last Medical Exam?__________ Date of last Dental Appt? __________
5.	Yes	No	Have you had problem with prior dental treatment? __________ What is your immediate dental problem?__________

II. HAVE YOU EXPERIENCED?

6.	Yes	No	Chest pain (angina)?	17.	Yes	No	Dizziness?
7.	Yes	No	Swollen ankles?	18.	Yes	No	Ringing in ears?
8.	Yes	No	Shortness of breath?	19.	Yes	No	Headaches?
9.	Yes	No	Recent weight loss, fever, night sweats?	20.	Yes	No	Fainting spells?
10.	Yes	No	Persistent cough, coughing up blood?	21.	Yes	No	Blurred vision?
11.	Yes	No	Bleeding problems, bruising easily?	22.	Yes	No	Seizures?
12.	Yes	No	Sinus problem?	23.	Yes	No	Excessive thirst?
13.	Yes	No	Difficulty swallowing?	24.	Yes	No	Frequent urination?
14.	Yes	No	Diarrhea, constipation, blood in stool?	25.	Yes	No	Dry mouth?
15.	Yes	No	Frequent vomiting?	26.	Yes	No	Jaundice?
16.	Yes	No	Difficulty urinating, blood in urine?	27.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD?

28.	Yes	No	Heart disease?	39.	Yes	No	AIDS or ARC
29.	Yes	No	Heart attack, heart defects?	40.	Yes	No	Tumors, cancer?
30.	Yes	No	Heart murmur?	41.	Yes	No	Arthritis, rheumatism?
31.	Yes	No	Rheumatic fever?	42.	Yes	No	Eye disease
32.	Yes	No	Stroke, hardening of arteries?	43.	Yes	No	Skin disease?
33.	Yes	No	High blood pressure?	44.	Yes	No	Anemia?
34	Yes	No	TB, emphysema, other lung disease?	45.	Yes	No	VD (syphillis or gonorrhea)?
35.	Yes	No	Hepatitis, other liver disease?	46.	Yes	No	Herpes?
36.	Yes	No	Stomach problems, ulcers?	47.	Yes	No	Kidney, bladder disease?
37.	Yes	No	ALLERGIS: to drugs or medications?	48.	Yes	No	Thyroid, adrenal disease?
38.	Yes	No	Family history of diabetes, heart problem, tumors?	49.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD?

50.	Yes	No	Psychiatric care?	54	Yes	No	Artificial joint?
51.	Yes	No	Radiation treatment?	55	Yes	No	Hospitalization?
52.	Yes	No	Chemotherapy?	56	Yes	No	Surgeries?
53.	Yes	No	Prosthetic heart valve?	57	Yes	No	Pacemaker?

V. ARE YOU TAKING?

58	Yes	No	Recreational drugs?	60.	Yes	No	Tobacco in any form?
59	Yes	No	Drugs, medicines (including Aspirin)?	61.	Yes	No	Alcohol?

Please list:__________, __________, __________
__________, __________, __________

VI. WOMEN ONLY:

62.	Yes	No	Are you or could you be pregnant or nursing?	63.	Yes	No	Taking birth control pills?

VII. HAVE YOU TAKEN

64. Yes No Weight control medication such as Phen-Fen?

VIII. ALL PATIENTS:

65. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain:__________

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's Signature __________ Date __________

RECALL REVIEW:

Patient's signature __________ Date __________

VIII. DOCTOR'S COMMENTS:

____
____
____