ADULT PATIENT INFORMATION

Date _____

Patient's Name _____ Preferred Name _____ Sex _____

Birthdate _____ Age _____ Social Security Number _____

Adress _____ City _____ Zip _____

Home Phone _____

Occupation _____ Employer _____

Employer Address _____ Wk phone _____

Cell Phone _____ Best Phone Number to Call _____
(If you don't have special preference, we'll call your cell phone as first priority)

e-mail address _____

Whom we may thank for referring you? _____

FAMILY ACCOUNT INFORMATION

Spouse's Name _____ Employer _____ Wk phone _____

Person responsible for account _____

IF other than self or spouse:

Name _____ Occupation _____

Address _____ City _____ phone _____

INSURANCE INFORMATION

	primary	**secondary**
Name of insured (Employee)		
Date of Birth (mo/day/year)		
Social Security number		
Insurance Company		
Group Number		

Assignment and release

I, the undersigned certify that I have insurance coverage.I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Lee or Dr. Yeh to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____ _____

Responsible Party Signature Relationship Date

This information is completely confidential.

Patient Name _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ **Phone** # _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check if you have had problems with any of the following

- □ Bad Breath
- □ Bleeding gums
- □ Clicking or popping jaw
- □ Grinding teeth
- □ Sensitivity to hot
- □ Loose teeth or broken fillings
- □ Periodontal treat treatment
- □ Sensitivity to cold
- □ Food collection between teeth
- □ Sensitivity to sweets
- □ Sensitivity when biting
- □ Sores or growths in mouth

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

MEDICAL HISTORY

Physicians Name _____ Date of last visit _____

Have you 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 _____

(Woman) Are you pregnant? □Yes □No Nursing? □Yes □No Taking Birth control pills? □Yes □No

Have you ever taken diet pills? □Yes □No If yes, please list _____

Check if you have or had any of the following

- □ AIDS
- □ Anemia
- □ Skin Rash
- □ Stroke
- □ Artificial Joints
- □ Asthma
- □ Back Problem
- □ Blood Disease
- □ Cancer
- □ Sleep Disorder
- □ Chemotherapy
- □ Venereal Disease
- □ Bulimia
- □ Cortisone Treatment
- □ Cough, Presistent
- □ Cough up Blood
- □ Diabetes
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Osteoporosis
- □ Heart Murmur
- □ Heart Problems, Describe _____
- □ Hemophilia
- □ Ulcer or Gastroesophageal reflux disorder
- □ Hepatitis
- □ Rheumatic Fever
- □ HIV Positive
- □ Jaw Pain
- □ Kidney Disease
- □ Liver Disease
- □ Thyroid Problem
- □ Nervous Problems
- □ Pacemaker
- □ Psychiatric Care
- □ Tonsillitis
- □ Tuberculosis
- □ High Blood Pressure
- □ Mitral Valve Prolapse
- □ Shortness of Breath
- □ Arthritis, Rheumatism
- □ Artificial Heart Valves
- □ Swelling Of Feet or Ankles
- □ Scarlet Fever
- □ Tobacco Habit
- □ Radiation Treatment
- □ Respiratory Disease
- □ Chemical Dependency
- □ Circulation Problems
- □ Acid Regurgitation

□ Medication for Osteoporosis (oral or IV, for how long): _____

MEDICATIONS

List medications you are currently taking

_____

_____

Pharmacy Name _____

Phone #: _____

ALLERGIES

- □ Aspirin
- □ Penicillin
- □ Sulfa
- □ Barbiturates
- □ Codeine
- □ (Sleeping pills)
- □ Local Anesthetics
- □ Other _____

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.

Today's Date _____ **Signature** _____