Patient Information

Date: _____ Patient ID (SSN): _____

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Age: _____ Birthday: _____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Minor ☐ Partnered for _____ years

Occupation: _____

Employer/School: _____

Employer/School Address: _____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

Spouse's Birthday: _____ Spouse's SSN: _____

Spouse's Employer/School: _____

Whom may we thank for referring you? _____

Contact Information

Home: (____) _____

Work: (____) _____ Ext: _____

Cell: (____) _____

Email: _____

Spouse's Work: (____) _____ Ext: _____

Spouse's Cell: (____) _____

Spouse's Email: _____

In **Case of Emergency**, whom may we contact?

(Please specify someone outside your household)

Name: _____

Relationship: _____

Home: (____) _____

Work: (____) _____ Ext: _____

Cell: (____) _____

Dental Insurance Information

Name of Insurance Plan Subscriber: _____ Relationship to Patient: _____

Insurance Company Name: _____ Group Number: _____

Subscriber Birthday: _____ Subscriber SSN: _____

☐ Yes ☐ No • Are you covered by additional insurance?

Name of subscriber for additional coverage: _____ Relationship to Patient: _____

Insurance Company Name: _____ Group Number: _____

Subscriber Birthday: _____ Subscriber SSN: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company(ies) and assign directly to Dr. Patricia M. Wong 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 whether manual or electronic.

Dr. Patricia M. Wong 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.

Acknowledgement: Receipt of Dental Materials Fact Sheet

☐ I acknowledge I have received a copy of the Dental Materials Fact Sheet.

Acknowledgement: Receipt of Notice of Privacy Practices

☐ I acknowledge I have received a copy of this office's Notice of Privacy Practices.

☐ I refuse to sign. (If this box is checked, your signature below only applies to the Acknowledgement of Receipt for the Dental Materials Fact Sheet)

Print Name	Signature	Date	Relationship to Patient

Area Below For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Communications barriers prohibited obtaining the acknowledgement ☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Individual refused to sign ☐ Other (please specify): _____

Dental History

Reason for today's visit: _____

Former Dentist: _____ Date of last dental visit: _____ Date of last dental x-rays: _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes ☐ No	Foreign objects	☐ Yes ☐ No	Pain around ear	☐ Yes ☐ No
Bleeding gums	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No	Periodontal treatment	☐ Yes ☐ No
Blisters on lips or mouth	☐ Yes ☐ No	Gums swollen or tender	☐ Yes ☐ No	Sensitivity to cold	☐ Yes ☐ No
Burning sensation on tongue	☐ Yes ☐ No	Jaw pain or tiredness	☐ Yes ☐ No	Sensitivity to heat	☐ Yes ☐ No
Chew on one side of mouth	☐ Yes ☐ No	Lip or cheek biting	☐ Yes ☐ No	Sensitivity to sweets	☐ Yes ☐ No
Cigarette, pipe, or cigar smoking	☐ Yes ☐ No	Loose teeth or broken fillings	☐ Yes ☐ No	Sensitivity when biting	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No	Mouth breathing	☐ Yes ☐ No	Sores or growth in your mouth	☐ Yes ☐ No
Fingernail biting	☐ Yes ☐ No	Mouth pain, brushing	☐ Yes ☐ No	How often do you floss?	_____
Food collection between the teeth	☐ Yes ☐ No	Orthodontic treatment	☐ Yes ☐ No	How often do you brush?	_____

Health History

Physician Name: _____ Date of last visit: _____

☐ Yes ☐ No • Are you under a physician's care now? (If "Yes" please specify: _____)

☐ Yes ☐ No • Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

☐ Yes ☐ No • Have you ever been hospitalized or had a major operation? (If "Yes" please specify: _____)

☐ Yes ☐ No • Have you ever had a serious head or neck injury? (If "Yes" please specify: _____)

☐ Yes ☐ No • Have you ever responded adversely to medical or dental treatment? (If "Yes" please specify: _____)

☐ Yes ☐ No • Have you ever experienced abnormal bleeding with extractions or surgery? (If "Yes" please specify: _____)

☐ Yes ☐ No • Do you wear contact lenses?

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Fainting or Dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type _____	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or Growth on Head / Neck	☐ Yes ☐ No
Cough, Persistent or Bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, Unexplained	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	* Other (specify): _____	

Women:

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Medications

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name: _____ Phone: ( ) _____

Allergies

Please indicate if you are allergic to any of the following:

☐ Aspirin ☐ Barbiturates (Sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa

☐ Other allergies (please specify): _____