Welcome to our practice! Dental care is more than repair. Our intention is to assist you in gaining and maintaining your best dental health. This includes: 1) restoring your teeth so that they are comfortable, functional and attractive; 2) treating your gum tisssue so that your "dental machine" can last your entire life-time; and 3) evaluating your general health and habits that may affect your future dental health.

Your answers to the following questions are the first step in determining your immediate and long-term dental care. Please add any comments you may have...the more we know about your needs and concerns the better we can serve you. Thank you!

DATE

FIRST NAME LAST NAME

NAME YOU WISH TO BE CALLED

HOME ADDRESS

CITY STATE ZIP

HOME PHONE NO. CELL NO.

WORK PHONE

EMAIL

BIRTHDATE AGE

MARRIED	SINGLE	DIVORCED	WIDOWED

SOCIAL SECURITY NO.

SPOUSE SPOUSE OCCUPATION

WHAT ARE YOUR PREFERRED METHODS OF CONTACTING YOU?

☐ EMAIL ☐ TEXT MESSAGING ☐ CELL PHONE ☐ HOME PHONE
☐ WORK PHONE ☐ FACEBOOK ☐ POSTCARD REMINDER

WHAT ARE YOUR PREFERRED DAYS FOR DENTAL APPOINTMENTS? (Please Circle)

Monday:	Mornings	Afternoons
Tuesday:	Mornings	Afternoons
Wednesday:	Mornings	Afternoons
Thursday:	Mornings	Afternoons
Friday:	Mornings	Afternoons

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

NAME OF INSURED

DATE OF BIRTH OF INSURED

SOCIAL SECURITY # OF INSURED

EMPLOYER

GROUP #

EFFECTIVE DATE PHONE

SECONDARY CARRIER

INSURANCE COMPANY

NAME OF INSURED

DATE OF BIRTH OF INSURED

SOCIAL SECURITY # OF INSURED

EMPLOYER

GROUP #

EFFECTIVE DATE PHONE

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME

RELATIONSHIP

SOCIAL SECURITY #

DRIVERS LICENSE NO.

BANK

BRANCH

ACCOUNT NO.

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE EXT.

GETTING TO KNOW YOU

OCCUPATION

EMPLOYER

BUSINESS ADDRESS CITY

BUSINESS TELEPHONE EXT.

REFERRED TO US BY

PERSON TO CONTACT FOR EMERGENCY PHONE NUMBER

ADDRESS

CITY STATE ZIP

CLOSEST RELATIVE NOT LIVING WITH YOU

PHONE NUMBER

ADDRESS

CITY STATE ZIP

HEALTH HISTORY

CIRCLE

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had a bad experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO

Physcian's Name _____

Address _____ Phone# _____

6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you now taking any medication, drugs or pills? ..... YES NO

if yes, please list: _____

8. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance such as Latex or local anesthetic? ..... YES NO

if yes, please list: _____

9. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure ..... YES NO	Emphysema ..... YES NO	Hepatitis (type _____) ..... YES NO
Heart Disease or Attack ..... YES NO	Cough, persistent or bloody ..... YES NO	Headaches ..... YES NO
Angina Pectoris ..... YES NO	Tuberculosis (TB) ..... YES NO	Liver Disease ..... YES NO
High Blood Pressure ..... YES NO	Asthma ..... YES NO	Yellow Jaundice ..... YES NO
Heart Murmur ..... YES NO	Hay Fever ..... YES NO	Blood Transfusion ..... YES NO
Rheumatic Fever ..... YES NO	Sinus Trouble ..... YES NO	Drug Addiction ..... YES NO
Congenital Heart Lesions ..... YES NO	Allergies or Hives ..... YES NO	Hemophilia ..... YES NO
Scarlet Fever ..... YES NO	Diabetes ..... YES NO	Venereal Disease
Artificial Heart Valve ..... YES NO	Thyroid Disease ..... YES NO	(Syphilis, Gonorrhea) ..... YES NO
Heart Pacemaker ..... YES NO	Chemotherapy (Cancer, Leukemia) YES NO	Cold Sores ..... YES NO
Heart Surgery ..... YES NO	Arthritis ..... YES NO	Fever Blisters ..... YES NO
Artificial Joints (Hip, Knee) ..... YES NO	Rheumatism ..... YES NO	Epilepsy or Seizures ..... YES NO
Anemia ..... YES NO	Cortisone Medicine ..... YES NO	Fainting or Dizzy Spells ..... YES NO
Stroke ..... YES NO	Glaucoma ..... YES NO	Nervousness ..... YES NO
Kidney Trouble ..... YES NO	Pain in Jaw Joints ..... YES NO	Psychiatric Treatment ..... YES NO
Ulcers ..... YES NO	HIV Positve or Aids ..... YES NO	Sickle Cell Disease ..... YES NO
Cosmetic Surgery ..... YES NO	Herpes ..... YES NO	Bruise Easily ..... YES NO
Mitral Valve Prolapse ..... YES NO		

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Have you lost or gained more than 10 pounds in the past? ..... YES NO
13. Do you ever wake up from sleep short of breath? ..... YES NO
14. Are you on a special diet? ..... YES NO
15. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
16. Do you have any disease, condition, or problem not listed? ..... YES NO
17. Do you smoke? ..... YES NO

if yes, how much? _____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No if yes, what month? _____. Are you taking birth control pills? ☐ Yes ☐ No

CONSENT:

The undersigned hereby authorizes Dr. Chu to take x-rays, study models, photographs, or any other disgnostic aids deemed appropriate by Dr. Chu to make a thorough diagnosis of the patient's dental needs. I also authorize Dr. Chu to perform any and all forms of treatment, medication and therapy that may be indicated for the patient's dental needs and wishes. I further authorize and consent that Dr. Chu choose and employ such assistance as deemed fit. I also realize that the use of anesthetic agents embodies certain risks, such as but not limited to, nerve paralysis and anaphylactic shock.

I understand that the responsibility of payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless prior financial arrangements have been made. I further understand that 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default (we) promise to pay legal interest on the indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection of this note. Bad or cancelled checks are subject to a $15.00 administrative fee. I understand and agree that (we) are fully responsible for any and all charges incurred at this office whether or not (we) have insurance.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient _____ Date _____ Witness _____

Parents or Responsible Party _____ Relationship to Patient _____