WELCOME

PATIENT INFORMATION

Date _____

SS # _____

Patient Name _____

Preferred Name _____

Address _____

City _____

State _____ Zip _____

E-Mail _____

Sex ☐ M ☐ F Age _____

Birth date _____

☐ Married ☐ Widowed ☐ Minor

☐ Separated ☐ Divorced ☐ Single

☐ Partnered

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (___) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Subscriber's Name _____

Birthdate _____ SS# _____

Is Patient covered by additional insurance? Yes No

Secondary Insurance Co. _____

Secondary Group # _____

ASSIGNMENT, RELEASE & FINANCIAL RESPONSIBILITY

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. CALVIN I. WHANG DDS all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

I understand that I am financially responsible for all charges whether or not paid by insurance. All unpaid balances in my and/or my family's account over 90days are subject to a finance charge of 1.5% per month until paid in full. In case suit or action is instituted to collect any amount due, patient promises to pay all collection costs and such additional sums as a court may adjudge reasonable.

The above-named doctor 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 upon written notification of departure from this practice.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

PHONE NUMBERS

Home ( ) _____ Work ( ) _____ ext ____ Cell Phone ( ) _____

Spouse's Work ( ) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name _____ Relationship _____

Home Phone ( ) _____ Work Phone ( ) _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ City/State _____

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

CONFIDENTIAL HEALTH HISTORY

Patient Name _____ Date of Birth _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
   Date of last dental exam _____ Name of last treating dentist _____
6. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (please circle all that apply)

Chest pain (angina)	Blood in stools	Frequent vomiting
Fainting spells	Diarrhea or constipation	Jaundice
Recent significant weight loss	Frequent urination	Dry mouth
Fever	Difficulty urinating	Excessive thirst
Night sweats	Ringing in ears	Difficulty swallowing
Persistent caugh	Headaches	Swollen ankles
Coughing up blood	Dizziness	Joint pain or stiffness
Bleeding problems	Blurred vision	Shortness of breath
Blood in urine	Bruise easily	Sinus problems

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (please circle all that apply)

Heart disease	AIDS/HIV	Psychiatric care
Family history of heart disease	Surgeries	Osteoporosis
Heart attack	Hospitalization	Thyroid disease
Artificial joint	Diabetes	Asthma
Stomach problems or ulcers	Family history of diabetes	Hepatitis
Heart defects	Tumors or cancer	Sexual transmitted disease
Heart murmurs	Chemotherapy	Herpes
Rheumatic fever	Radiation	Canker or cold sores
Skin disease	Arthritis, rheumatism	Anemia
Hardening of arteries	Emphysema or other lung disease	Liver disease
High blood pressure	Kidney or bladder disease	Eye disease
Seizures	Stroke	Transplants
Cosmetic surgery	Eating disorders	Tuberculosis

IV. ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO ANY OF THE FOLLOWING? (please circle all that apply)

Aspirin	Valium	Tetracycline
Darvon	Demerol	Vicodin
Codeine	Penicillin	Percodan
Local anesthetic (Novacaine, Xylocaine)	Latex	Food
Nitrous Oxide	Erythromycin	Metal

Others _____

_____

HEALTH HISTORY (cont'd)

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (please circle)

Recreational drugs	Tobacco in any form	Antibiotics
Over-the-counter medicine	Alcohol	Supplements
Weight loss medications	Bisphosphonate (Fosamax)	Aspirin

Please list _____

_____

VI. WOMEN ONLY

Yes No Are you or could you be pregnant?

If YES, what month? _____

Yes No Are you nursing?

Yes No Are you taking birth control pills?

VII. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, pleas explain _____

_____

Yes No Have you ever been pre-medicated for dental treatment?

If YES, why _____

Yes No Have you ever taken Fen-Phen? If YES, when _____

Yes No Are there any issues or conditions that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature _____ Date _____

Physician's Name _____ Phone _____

I certify that I have read and understand this form. 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. Further, 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 completion of this form.

_____ _____ _____ _____

Signature of Patient (Parent/Guardian) *Date* *Signature of Dentist* *Date*

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials