Patient Information Form

Today's Date:___________

Patient Name:______________________________ **Date of Birth:**________________

Address: Street__________________ City_______________ State_____ Zip__________

Phone: Home_______________ Work________________ Moblie_____________________

Email address: ________________________________ **Sex:** ___Male ___Female

Social Security Number: _________________ **Drivers License #:** _________________

Employer: ____________________________ Phone # _______________________

Marital Status ___Married ___Single ___Divorced ___Separated ___Widowed

Spouse, partner, or parent name:____________________________

Who is responsible for your account and payments? _________________________

How did you learn about our practice or whom may we thank for referring you?

____

Emergency Contact

Person to contact in case of an emergency: ________________________

Phone: Home_______________ Work________________ Moblie_____________________

Address: Street__________________ City_______________ State_____ Zip__________

Insurance Information

Patient Employed By: _____________________ Occupation______________________

Address: Street__________________ City_______________ State_____ Zip__________

Phone: _____________________

Primary Dental Insurance

Insurance Company: ______________________________ Phone # _____________________

Subscriber's Name: _____________________________ Date of Birth___________________

Subscriber's Social Security #_______________________ Zip Code____________________

Member ID #_________________________

Secondary Dental Insurance

Insurance Company: ______________________________ Phone # _____________________

Subscriber's Name: _____________________________ Date of Birth___________________

Subscriber's Social Security #_______________________ Zip Code____________________

Member ID #_________________________

Dental History (Please have all previous records sent to us at yulanwudds1@gmail.com)

Reason for today's visit: ____

Date of last dental care visit _________________ Date of last dental x-rays______________

Former Dentist's Name: ___________________________ Phone _________________________

Check if you have any of the following problems:

____ Bad breath

____ Bleeding gums

____ Clicking or popping jaw

____ Food collection between certain teeth

____ Grinding teeth

____ Loose/broken teeth or fillings

____ Periodontal treatment

____ Sensitivity to cold, hot, sweets

____ Sensitivity when biting

____ Sores or growth in your mouth

How often do you floss? _____________ How often do you brush your teeth? ___________

Medical History

Name of Physician: ____

Date of most recent physical examination: ________________ Purpose: ______________

What is your estimate of your general health? ___Excellent ___Good ___Fair ___Poor

Have you had any illness, operation, or been hospitalized in the past five years? _________

Please use an "**X**" to mark your answers to the following questions.

Do you have, or have you been diagnosed with any of the following conditions?

Yes	No	Condition
__	__	1. Rheumatic Fever
__	__	2. Mitral Valve Prolapse
__	__	3. Heart Murmur
__	__	4. High Blood Pressure
__	__	5. Low Blood Pressure
__	__	6. Chest Pain / Angina
__	__	7. Heart Attack(s)
__	__	8. Irregular Heart Beat
__	__	9. Cardiac Pacemaker
__	__	10. Heart Surgery
__	__	11. Pneumonia
__	__	12. Bronchitis
__	__	13. Chronic Cough
__	__	14. Chronic Fatigue
__	__	15. Night Sweat
__	__	16. Trouble Climbing Stairs
__	__	17. Mental Health Problems
__	__	18. Damaged Heart Valves
__	__	19. Asthma
__	__	20. Immunosuppressed
__	__	21. Hay Fever / Sinus Problems
__	__	22. Snoring / Sleep Apnea
__	__	23. Respiratory Problems
__	__	24. Tuberculosis
__	__	25. Emphysema
__	__	26. Do you smoke
		If so, # packs a day _____
__	__	27. Use Chewing Tobacco
__	__	28. Blood Transfusion
__	__	29. Blood Disorder
__	__	30. Bruise Easily

Yes	No	Condition
__	__	31. History of Drug Abuse
__	__	32. Eye Disease/ Glaucoma
__	__	33. Abnormal Bleeding
__	__	34. Bleeding Tendency
__	__	35. Immune System Problems
__	__	36. Jaundice / Liver Disease
__	__	37. Hepatitis
__	__	38. Infectious Mononucleosis
__	__	39. Gallbladder Trouble
__	__	40. Fainting Spells
__	__	41. Convulsions / Epilepsy
__	__	42. Stroke
__	__	43. Thyroid Trouble
__	__	44. Diabetes
__	__	45. History of Alcohol Abuse
__	__	46. Sexually Transmitted Diseases
__	__	47. Swollen Ankles
__	__	48. Low Blood Sugar
__	__	49. Kidney Trouble
__	__	50. On Dialysis
__	__	51. Arthritis / Joint Disease
__	__	52. Prosthetic Joint / Implant
__	__	53. Osteoporosis / Osteopenia
__	__	54. Osteonecrosis
__	__	55. Stomach Ulcers
__	__	56. Contagious Diseases
__	__	57. Delay in Healing
__	__	58. Anemia
__	__	59. Tumor or Growth
__	__	60. Cancer / Radiation / Chemo
__	__	61. Contact Lenses

Other: ______________________

Medication & Allergies

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatments?

___Yes ___No

Have you, or a family member, had any unusual or serious reactions to general anesthesia? ___Yes

___ No

Please use an "**X**" to mark your answers to the following questions.

Are you now taking, or have you ever taken:

Yes No

__ __ 1. Nerve Pills
__ __ 2. Diet Pills
__ __ 3. Blood Thinners (Coumadin, Aspirin, Advil)
__ __ 4. Any Bone Density Medication or Bisphosphonates (Aredia, Zometa, Fozamax, Actonel)
__ __ 5. Pain Killers (including Aspirin)
__ __ 6. Tranquilizers
__ __ 7. Muscle Relaxers
__ __ 8. Insulin
__ __ 9. Stimulants
__ __ 10. Antidepressants

Please list any other medications you are taking, dosage, frequency (including natural, herbal, or homeopathic products):

____

____

Are you allergic to, or had a reaction to:

Yes No

__ __ 1. Penicillin
__ __ 2. Sodium Pentothal / Valium / other tranq.
__ __ 3. Soy
__ __ 4. Sulfa Drugs
__ __ 5. Aspirin
__ __ 6. Eggs / Yolk
__ __ 7. Local Anesthetic (numbing med)
__ __ 8. Codeine or Other Narcotics
__ __ 9. Amoxicillin
__ __ 10. Latex
__ __ 11. I have no known allergies

Please list any other medication or antibiotic you are allergic to:

____

Women Only

(Women Note: antibiotics such as penicillin may alter the effectiveness of birth control pills. Please Consult your physician / gynecologist for assistance regarding additional methods of birth control)

1. Is there a possibility of pregnancy? ___Yes ___No
2. Expected delivery date: ________________
3. Are you nursing? ___Yes ___No
4. Are you taking birth control pills? ___Yes ___No

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION YOU MAY BE TAKING.

Patients please read and sign below:

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X______________________________ **X**____________________________ Date_________

Signature of patient (Parent or Guardian if minor) Reviewed by

Policy Form

APPOINTMENT POLICY

When you make an appointment with our office, we consider this a mutual commitment and reserve appropriate facilities and staff exclusively for you. Our office policy states that patients must give us 2 business days or 48 hours notice if they cannot keep an appointment. Appointment changes with less than 2 days notice are subject to a service fee of $35.00.

FINANCIAL POLICY

Payment in full is due the day of treatment, or on upon the start of major treatment. Should a patient have dental insurance, the estimated patient portion will be the amount due.

Payment Options

1. For your convenience we accept Cash (in the exact amount), Check, & Card payments.

2. We also offer short-term financing options but all arrangements must be made in advance and are subject to an approval process.

For Patients with Dental Insurance

Dental insurance plans often pay less than the actual fee for service. Therefore the patient or Guarantor is the responsible party for all dental services provided. Dental insurance in most cases is a benefit with limitations and should not be expected to take care of all costs. **You are ultimately responsible for all costs incurred regardless of what your dental insurance covers!**

Finance Charge and Fees

- Balances in excess of 30 days are subject to a finance charge of 2% per month (24% per annum).
- Returned checks are subject to a $35 accounting fee.

AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination by Dr. Yulan Wu. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no

guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Dr. Yulan Wu to release any information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Dr. Yulan Wu.

I understand and will comply with the office **Appointment Policy**.

I understand and will comply with the office **Financial Policy**.

I understand and agree to the **General Consent to Treatment**.

I authorize the **Release of Information**.

I authorize the **Assignment of Insurance Benefits**.

X ____ Date ______________________

Signature of patient (Parent or guardian if minor)

Oral Surgery Information (only for patients who have had oral surgery)

If you haven't already, please call your oral surgeon to have all previous x-rays, implant information, or any oral surgery information emailed to us at yulanwudds1@gmail.com.

Dental Info:

What type of oral surgery did you have: ____

____

____

What year/years was your oral surgery done: ____

Surgeon Info:

Oral Surgeon Name:________________________________

Oral Surgeon Phone Number: ________________________

Oral Surgeon Address: ______________________________

Oral Surgeon Email: ________________________________

Surgeon Info (if you had more than one surgeon):

Oral Surgeon Name:________________________________

Oral Surgeon Phone Number: ________________________

Oral Surgeon Address: ______________________________

Oral Surgeon Email: ________________________________