RAYMOND K. CHAN, DDS

#_____

Patient Information

Date _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Driver License # _____

Birthdate _____

SS# _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School _____

Occupation _____

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 # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr._____ 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.

The above-named dentist 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.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please 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 _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

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

How often do you floss? _____

How often do you brush? _____

Dental Registration and History

MEDICAL HISTORY

Patient Name _____ Birthdate _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you every had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women:
Are you: Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ Other - If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Drug Addiction	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Easily Winded	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Epilepsy or Seizures	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Excessive Bleeding	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Other _____	☐ Yes ☐ No

Comments _____

Physician's Name _____ Phone _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian _____ Date _____

Doctor's Initial _____