south oc Dentistry
Where smiles start.

Jane Cho, DDS

Tell Us About You

Today's Date: ______ Name: ______ Birthdate: ______ Age: ______

Nickname: ______ ❒ Male ❒ Female Home Phone #: (____) ______ Cell Phone#: (____) ______

Home Address: ______ Social Security #: ______
Street City State Zip

Occupation: ______ Employer: ______ Length of Employment: ______

Employer's Address: ______ Business Phone #: (____) ______

E-mail: ______ Marital Status: ❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed

Has any member of your family been or is currently a patient in this office? ❒ Yes ❒ No If Yes, name: ______

Emergency Contact: ______ Relationship to you: ______ Cell Phone #: (____) ______

Nearest Relative: ______ Address: ______ Phone #: (____) ______

Who may we thank for referring you? ______

If you are completing this form for the patient, what is your relationship to the patient? ❒ N/A

Your Name: ______ Relationship: ______

Insurance Information

Primary Insurance

Insurance Co. Name: ______ Phone #: (____) ______ Group # (Plan, Local, or Policy#): ______

Insurance Co. Address: ______
PO Box / Street City State Zip

Insured's Name: ______ Relationship to Patient: ______

Insured's Address (if different from above): ______ Home Phone #: (____) ______

Insured's Birthdate: ____/____/____ Social Security #: ______ Insured's Employer: ______

Secondary Insurance

Insurance Co. Name: ______ Phone #: (____) ______ Group # (Plan, Local, or Policy#): ______

Insurance Co. Address: ______
PO Box / Street City State Zip

Insured's Name: ______ Relationship to Patient: ______

Insured's Address (if different from above): ______ Home Phone #: (____) ______

Insured's Birthdate: ____/____/____ Social Security #: ______ Insured's Employer: ______

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided to me, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf.

X ______
Signature Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to me during the period of such dental care to third party payors and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my Protected Health Information to carry out treatment, payment activities and healthcare operations.

X ______
Signature Date

______
Reviewing Doctor's Signature Date

Dental History

What is the reason for your visit today? ____________________

Previous Dentist: ____________ Date of your last exam: ________ Date of last x-rays: ________

What did you like most about any dentist you've seen? ____________ Least? ____________

Is there anything you would change about your smile? ____________________

Medical History

Please mark your response to indicate if you have or have not had any of the following. Check DK if you Don't Know the answer to the question.

Are you now under the care of a physician? ❒ Yes ❒ No ❒ DK

Physician Name: ____________ Phone: ____________

Address/ City/ State/ Zip: ____________________

Are you in good health? ❒ Yes ❒ No ❒ DK

Has there been any change in your general health within the past year? ❒ Yes ❒ No ❒ DK

If Yes, what condition is being treated? ____________________

Date of last physical exam: ____________________

Medications.

	Y	N	DK
Are you taking or have you recently taken any medication(s) including non-prescription medicine?	❒	❒	❒

If Yes, what medication(s) are you taking?

Prescribed: ____________________

Over the counter: ____________________

Vitamins, natural or herbal prescriptions and/or diet supplements: ____________________

	Y	N	DK
Artificial (Prosthetic) Heart Valve	❒	❒	❒
Previous Infective Endocarditis	❒	❒	❒
Damaged Valves in Transplanted Heart	❒	❒	❒
Congenital Heart Disease	❒	❒	❒
Heart Problems			
Chest Pain	❒	❒	❒
Shortness of Breath	❒	❒	❒
Heart Murmur	❒	❒	❒
Taking Heart Medications	❒	❒	❒
Rheumatic Fever	❒	❒	❒
Pacemaker	❒	❒	❒
Heart Attack/Cardiovascular Disease	❒	❒	❒
Family History of Heart Disease	❒	❒	❒
Blood Problems			
Easy Bruising	❒	❒	❒
Frequent Nosebleeds	❒	❒	❒
Abnormal Bleeding	❒	❒	❒
Blood Disease (Anemia)	❒	❒	❒
Ever Require a Blood Transfusion?	❒	❒	❒
Diabetes (Type I or II)	❒	❒	❒
Urinate more than 5 times a day?	❒	❒	❒
Thirsty or mouth is dry much of the time	❒	❒	❒
Family history of Diabetes	❒	❒	❒
Tuberculosis or other Respiratory Disease	❒	❒	❒
Asthma	❒	❒	❒

	Y	N	DK
Bone or Joint Problems			
Arthritis	❒	❒	❒
Back or Neck Pain	❒	❒	❒
Osteoporosis	❒	❒	❒
Intestinal Problems			
Ulcers	❒	❒	❒
Sudden Weight Gain or Loss	❒	❒	❒
Special Diet	❒	❒	❒
Constipated Diarrhea	❒	❒	❒
Kidney and Bladder Problems	❒	❒	❒
Cancer/Chemotherapy/Radiation Treatment	❒	❒	❒
GE Reflex/Breathing Difficulty	❒	❒	❒
Autoimmune Disease	❒	❒	❒
Neurological Disorders	❒	❒	❒
If Yes, Specify ____________			
Mental Health Disorders	❒	❒	❒
If Yes, Specify ____________			
Hepatitis, Jaundice or Liver Trouble	❒	❒	❒
Herpes or other STD	❒	❒	❒
HIV Positive / AIDS	❒	❒	❒
Sinus Trouble	❒	❒	❒
Sleep Disorders	❒	❒	❒
Do You Snore?	❒	❒	❒

	Y	N	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❒	❒	❒

If yes, what was the illness or problem? ____________

Joint Replacement

	Y	N	DK
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❒	❒	❒

Date: ____________

If yes, have you had any complication? ____________

	Y	N	DK
Do you use controlled substances (drugs)?	❒	❒	❒
Do you use tobacco? (Smoking, snuff, chew,bidis)	❒	❒	❒

If so, how interested are you in stopping?

Circle One: Very / Somewhat / Not Interested

	Y	N	DK
Do you drink alcoholic beverages?	❒	❒	❒

Allergies

Are you allergic to or have you had a reaction to:
To all YES responses, specify type of reaction.

Y	N	DK	
❒	❒	❒	Local Anesthetics ____________
❒	❒	❒	Aspirin ____________
❒	❒	❒	Penicillin or Other Antibiotics ____________
❒	❒	❒	Barbituates, Sedatives or Sleeping Pills ____________
❒	❒	❒	Sulfa Drugs ____________
❒	❒	❒	Codeine or Other Narcotics ____________
❒	❒	❒	Metals ____________
❒	❒	❒	Latex Rubber ____________
❒	❒	❒	Iodine ____________
❒	❒	❒	Hay Fever / Seasonal ____________
❒	❒	❒	Animals ____________
❒	❒	❒	Food ____________
❒	❒	❒	Other ____________

WOMEN ONLY / Are you?

	Y	N	DK
Pregnant	❒	❒	❒
Number of weeks ____________			
Taking Birth Control Pills or Hormonal Replacement	❒	❒	❒
Nursing	❒	❒	❒

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ❒ Yes ❒ No ❒ DK

If Yes, Name of physician or dentist making recommendation: ____________ Phone #: (____) ____________

Do you have any disease, condition or problem not listed that you think we should know about? ❒ Yes ❒ No ❒ DK

If Yes, please explain: ____________________