ALHAMBRA DENTAL GROUP

PATIENT INFORMATION FORM

Patient's Name: Mrs., Mr., Ms. _____ Date of Birth _____ Age _____

IF PATIENT IS A MINOR, RESPONSIBLE PARTY SHOULD FILL OUT EMPLOYMENT INFORMATION

Parent or Guardian's Name (if minor) _____

Residence Address _____

How Long _____ Email _____ Fax _____

City _____ State _____ Zip _____ Phone _____ Cell Phone _____

Occupation (Parent/Guardian) _____ Employer _____ Phone _____

Employer Address _____

Spouse's Name _____ Phone _____ Cell Phone _____

Spouse's Occupation _____ Employer _____ Phone _____

Employer's Address _____

Person financially responsible _____ Relation to you _____

Social Security Number (Mr.) _____ Children – Names & Ages _____

(Ms.) _____ _____

Do you wish to have a relative or friend assist you in the decision making of your dental treatment?

If **Yes**, Name: _____ Phone Number _____

If **No**, **PATIENT'S SIGNATURE**: _____

Previous Dentist _____ Date of most recent visit/procedure _____

Emergency Contact (name): _____ Relationship _____ Phone _____

We always want to express our special appreciation to patients who refer others to us.
Please indicate below how you came to know about us.

Name _____

☐ **Physician/Dentist** ☐ **Friend/Relative** ☐ **Other source of Referral** _____

Dental Benefits Assignment

PAYMENT IS DUE IN FULL AT TIME APPOINTMENT FOR SERVICES ARE SCHEDULED

Dental Benefits Carrier _____ **Secondary Carrier** _____

If Patient is a student – Name of School _____

NOTE: We *do not pre-authorize* treatment. We will provide you with an ***estimate*** of benefits based on available information and previous experience with your plan.

I hereby assign dental benefits to the Alhambra Dental Group and authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my dental plans. This release is solely for the purpose of facilitating the billing reimbursement, directly to the doctor, or dental benefits to which I am entitled.

_____ _____

Signature of Patient/Parent or Guardian Signature of Insured Party

We are concerned with your oral health as well as your total well-being. An essential part of our approach is a thorough health history. Please fill out the following health questionnaires completely. Thank You.

1. Name, address, and phone number of family physician._____

2. ____YES ____NO Are you now under current medical treatment? If yes explain

3. Do you now have, or ever had any of the following: (**for each item please WRITE*: YES or NO,* do not leave any blanks and do not cross a line through any items**).

a. _____Hepatitis/liver disease
b. _____Thyroid
c. _____Heart Ailment
d. _____High Blood Pressure
e. _____Lung Disease/TB
f. _____Diabetes
g. _____Stroke/Heart Attack
h. _____Physical Disability
i. _____Spinal Bifida
j. _____Rheumatic Fever
k. _____Rheumatism or Arthritis
l. _____Tumors or Growths
m. _____Any Blood Diseases
n. _____Any Kidney Disease
o. _____Stomach or Intestinal Disease
p. _____Heart Valve Abnormality
q. _____Phen Phen use
r. _____Aphasia (problems swallowing or breathing).
s. _____Elevated Cholesterol
t. _____Shortness of Breath
u. _____Prolonged Bleeding
v. _____Venereal Diseases
w._____Mental Disability
x. _____Chicken Pox
y. _____HIV +
z. _____Psychiatric Treatment
aa._____Cancer—Type & Date: _____
bb. _____Dry Mouth
cc. _____Osteoporosis
dd._____ Acid Reflux
ee. ____ Have you ever been diagnosed with with Mononucleosis?
ff. ____ Have you ever been diagnosed with Epstein-Barr virus?
gg. Sleep Apnea
- CPAP _____
- Oral Appliance
- Sleep Study_____

hh. ____ Bruises Easily

OTHER: _____

4. Chief Complaint:_____

YES____NO____**5.** Have you had any operations or prosthetic implants (e.g. hip or heart valve, etc.)? If yes, please explain: _____

YES____NO____**6.** Are you allergic to any known materials or solutions? Iodine/Seafood_____, Acrylic_____, Latex_____, Talcum Powder_____, Medication (name)_____, OTHER:_____

YES____NO____**7.** Are you now taking drugs, medications, or herbal health supplements? If yes, please list name, and dosage_____.

YES____NO____**8.** Have you ever used recreational drugs?

YES____NO____**9.** Have you ever Hyperventilated or suffered from episodes of Hypoglycemia?

YES____NO____**10.** Do you have a history of fainting or convulsions?

YES____NO____**11.** Have you ever had any X-ray treatments (other than diagnostics)?

YES____NO____**12.** Have you ever had an adverse response to anesthetics in any form? If yes, please Explain: _____

YES____NO____**13.** Are you now pregnant, or may be in the near future? If yes, how many months?_____

YES____NO____**14.** Do you have asthma, hay fever, frequent sore throats or sinusitis?

YES____NO____**15.** Does your diet include ***excessive***:(1)sugary foods____(2) citric foods____(3) hard/crunchy foods____.

YES____NO____**16.** Are you especially afraid of “shots”, we specialize in cowards.

YES____NO____**17.** Do you require pre-medication prior to dental treatment, due to a heart condition or rheumatic fever?

YES____NO____**18.** Do you mouth breathe?

YES____NO____**19.** Have you ever been told you have “TMJ” (jaw joint) problems or had your bite adjusted?

YES____NO____. 20. Have you ever worn braces to straighten your teeth?

YES____NO____. 21. Have you noticed loosening or drifting of your teeth?

YES____NO____. 22. Have you ever diagnosed as having or been treated for gum disease?

YES____NO____. 23. Do you smoke? If yes, _____ packs per day. How many years?_____.
Have you ever had lung x-rays done? If yes, when_____

YES____NO____. 24. Have you ever had growth tumors in the mouth or throat? If yes, please explain.
_____

YES____NO____. 25. Do you drink alcohol? If yes, Light_____, Moderate_____, Heavy_____.

YES____NO____. 26. Has any member of your immediate family been diagnosed for diabetes, dementia,
YES____NO____. Parkinsons, Alzheimer?

YES____NO____. 27. Have you noticed a bad taste or smell in your mouth?

YES____NO____. 28. Does any part of your body feel numb, and/or painful during or after dental treatment?

YES____NO____. 29. Do you experience dizziness regularly or periodically?

30. Have you ever had an accident involving your face, head, jaws, neck or spine?
If yes, briefly explain: _____

YES____NO____. 31. Do you snore? Unknown _____

YES____NO____. 32. Do you experience day time tiredness?

YES____NO____. 33. Have you ever experienced jaw pain, clicking, locking, or ringing in the ear?

RELEASE OF INFORMATION FOR EDUCATIONAL PURPOSES

With the permission of his patients, Dr. Chao occasionally uses photographs and X-rays of his patients in his presentation to various dental organizations. Dr. Chao also uses this kind of information as illustration in dental health columns that appears in various local newspapers. Your cooperation in allowing Dr. Chao to use photographs of your mouth would be greatly appreciated. Only your smile and your teeth may be shown and you will NOT be identifiable.

I hereby give consent to John Chao, D.D.S., the right to use in perpetuity any information of my treatment, including X-rays, photographs, slides, casts, and models for purposes associated with dental education, such a s dental seminars, publications, and presentations to professional groups or the general public. I understand this release does NOT include the use of my name or identity.

PATIENT SIGNATURE _____ **DATE** _____

CONSENT FOR DIAGNOSIS AND TREATMENT

The undersigned hereby authorizes John Chao, D.D.S. and staff to provide all necessary diagnostic and treatment services.

PATIENT/PARENT/GUARDIAN _____ **DATE**_____

HEALTH UPDATE _____ **DATE**_____

HEALTH UPDATE _____ **DATE**_____

HEALTH UPDATE _____ **DATE**_____

HEALTH UPDATE _____ **DATE**_____

HEALTH UPDATE _____ **DATE** _____