

WELCOME TO OUR PRACTICE!



PATIENT INFORMATION - ADULT FORM

Today's Date: _____

Patient's Name: _____ SSN: _____
Last First Middle

Date of Birth: _____ Age: _____ Sex: F M

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Employer Phone #: _____

Marital Status: Single Married Divorced Widowed Separated

Spouse's Name: _____ DOB: _____ SSN: _____

Occupation: _____ Spouse's Employer: _____

Whom may we thank for referring you? _____

CONTACT INFORMATION

Home Phone #: _____ Cell Phone #: _____

E-mail: _____

Best time to reach you: _____

In Case of an Emergency, Contact (Please Specify): _____

Home #: _____ Work #: _____ ext. _____ Relationship: _____

Can we e-mail and/or send a text message to your cell to confirm your appointment?

Yes, Both are ok Only email Only Txt Cell No, I'd prefer a phone call.

INSURANCE INFORMATION

DENTAL INSURANCE

Insurance Co.: _____ Group (Policy) #: _____

Ins. Co. Address: _____ Insurance Co. Phone #: _____

Policy Owners Name: _____ Relationship to Patient: _____

Policy Owner's DOB: _____ SSN: _____

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Tong 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Relationship _____ Date _____

Responsible Party Signature

Name: _____ DOB _____

MEDICAL ALERTS

List any medications you are taking and the correlating diagnosis:

Pharmacy Name: _____ Phone #: _____

Allergies

- Aspirin Barbiturates (Sleeping Pills) Sulfa
- Local Anesthetics Penicillin (Amoxicillin)
- Codeine Iodine Latex
- Other _____

DENTAL HISTORY

Reason for today's visit: _____	Bad breath	Yes / No	Jaw pain/tiredness	Yes / No
_____	Bleeding gums	Yes / No	Loose/broken tooth	Yes / No
Former Dentist: _____	Burning Sensation	Yes / No	Fillings	Yes / No
Phone #: _____	On tongue	Yes / No	Mouth breathing	Yes / No
Date of last dental visit: _____	Chew on one side	Yes / No	Mouth pain, brushing	Yes / No
Date of last dental x-ray: _____	Of mouth	Yes / No	Pain around ear	Yes / No
How often do you brush? _____	Cigarette/pipe/cigar smoking	Yes / No	Periodontal treatment	Yes / No
How often do you floss? _____	Clicking/popping jaw	Yes / No	Sensitivity of cold	Yes / No
Please circle "yes" or "no" to indicate if you have any of the following:	Dry mouth	Yes / No	Sensitivity to heat	Yes / No
	Food collection btwn teeth	Yes / No	Sensitivity when biting	Yes / No
	Grinding teeth	Yes / No	Sores/growths in your mouth	Yes / No
	Gums swollen/tender	Yes / No		

HEALTH HISTORY

Physician's Name: _____ Phone #: _____

Please circle "yes" or "no" to indicate if you have any of the following:

AIDS/HIV	Yes / No	Epilepsy	Yes / No	Respiratory Disease	Yes / No
Anemia	Yes / No	Fainting or Dizziness	Yes / No	Rheumatic Fever	Yes / No
Arthritis/Rheumatism	Yes / No	Glaucoma	Yes / No	Scarlet Fever	Yes / No
Artificial Heart Valves	Yes / No	Headaches	Yes / No	Shortness of Breath	Yes / No
Artificial Joints	Yes / No	Heart Murmur	Yes / No	Sinus Trouble	Yes / No
Asthma	Yes / No	Heart Problems	Yes / No	Skin Rash	Yes / No
Back Problems	Yes / No	Hepatitis Type ____	Yes / No	Special Diet	Yes / No
Bleeding Abnormally		Herpes	Yes / No	Stroke	Yes / No
w/extractions or surgery	Yes / No	High Blood Pressure	Yes / No	Swollen Feet Ankles	Yes / No
Blood Disease	Yes / No	Jaundice	Yes / No	Swollen Neck Glands	Yes / No
Cancer	Yes / No	Jaw Pain	Yes / No	Thyroid Problems	Yes / No
Chemical Dependency	Yes / No	Kidney Disease	Yes / No	Tonsillitis	Yes / No
Chemotherapy	Yes / No	Liver Disease	Yes / No	Tuberculosis	Yes / No
Circularity Problems	Yes / No	Low Blood Pressure	Yes / No	Tumor or Growth On	Yes / No
Congenital Heart Lesions	Yes / No	Mitral Valve Prolapse	Yes / No	Head or Neck	Yes / No
Cortisone Treatments	Yes / No	Nervous Problems	Yes / No	Ulcer	Yes / No
Cough, Persistent or Bloody	Yes / No	Pacemaker	Yes / No	Venereal Disease	Yes / No
Diabetes	Yes / No	Psychiatric Care	Yes / No	Weight Loss, Unexplained	Yes / No
Emphysema	Yes / No	Radiation Treatment	Yes / No		

WOMEN: Are you pregnant? Yes / No Due Date: _____ Are you nursing? Yes / No
Taking Birth control? Yes / No

Authorization

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and is my responsibility to inform this office of any changes.

Signature

date