WELCOME

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health.

About You

Today's Date:

Patient Name: ______________________________________
I prefer to be called: _________________________________
Date of birth: ______________________________________
SS #: _________________ DL #:________________________
Home address: ______________________________________
City: _____________________ State: _______ Zip: ________

Male ____ Female ____
Billing address (if different):______________________________
City: ____________________ State: _______ Zip: ____________
Single___ Married___ Widowed___ separated___ Divorced___
Spouse's name: ____
Their Employer: __________________ phone #: ______________

Contact

Home phone: ____
Cell phone: ____
E-mail: ____
Best time and place to reach you? ________________________
Preferred appointment days: M T W Th F AM/PM
Are you available for short notice appointments? . . . . . . Y N

Employer

Your employer: ____
Occupation: ____
Work phone: ____
Address: ____
City: ___________________ State: _________ Zip: ____________
Who may we thank for referring you? ______________________

Insurance Coverage:

Do you have dental insurance? . . . . Y N
Primary dental insurance: _______________________________
Address: ____
City: ___________________ State: ________ Zip: ____________
Group #: ____________________ ID #: ____________________
Subscriber's name: ____________________________________
Employer: ____
Insured's date of birth: _____________ SS #: _______________
Is this insurance new to you? ____________________________

Secondary Insurance:

Do you have Secondary dental insurance? . . . . Y N
Secondary dental insurance: ____________________________
Address: ____
City: ____________________ State: _______ Zip: ___________
Group #: __________________ ID#: _______________________
This coverage is through: Spouse ____Parent____ Other_____
Their name: ____
Their employer: _______________________________________
Their date of birth: ____________Their SS #: ______________

Two Emergency Contacts (other than spouse)

Name: __________________________________ Phone #: ____________________________ Relationship: _______________________
Name: __________________________________ Phone #: ____________________________ Relationship: _______________________

VIVIAN H. BAE D.D.S.

Dental History

Previous Dentist: ___________________________ Last visit: ____________

Phone #: ________________________ City: __________________________

Are you apprehensive about dental treatment? . . . . Y N

Do your gums bleed when you floss or brush? . . . . Y N

Have you noticed slow-healing sores in your mouth? . . . . Y N

Are you dissatisfied with the appearance of your teeth? . . . . . . Y N

Do you use tobacco? . . . . Y N

If yes, how often? __________________

Do you take fluoride supplements? . . . . Y N

Have you ever had orthodontics (braces)? . . .Y N

Do you wear dentures/partials? . . . . Y N

Are your teeth sensitive to hot or cold? . . . . . Y N

Do you clench or grind your teeth? . . . . Y N

Do you experience any jaw discomfort? . . . . Y N

Do you want complete dental care? . . . . Y N

How often do you brush? __________ Floss? _________

Medical History

Do you require antibiotics prior to dental treatment? . . . Y N

If yes, please explain: _______________________________

____

Have you ever been hospitalized? . . . . Y N

If yes, please explain: _______________________________

____

Do you have a personal physician? . . . . Y N

His/her name: ____

Phone #: ____

Are you currently under the care of ANY physician? . . . . . Y N

If yes, please explain: _________________________________

Your current health is: Good ______ Fair ______ Poor ______

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

- ☐ AIDS/HIV positive
- ☐ Angina
- ☐ Drug addictions
- ☐ Heart attack/failure
- ☐ High/low blood pressure
- ☐ Lung disease
- ☐ Pacemaker
- ☐ Shingles
- ☐ Surgery
- ☐ Anemia
- ☐ Cancer
- ☐ Seizures/convulsions
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Mitral valve prolapsed
- ☐ Radiation treatment
- ☐ Sinus trouble
- ☐ STD
- ☐ Joint replacement
- ☐ Chemotherapy
- ☐ Excessive bleeding
- ☐ Hepatitis A
- ☐ Leukemia
- ☐ MRSA
- ☐ Rheumatic fever
- ☐ Stomach/intestinal disease
- ☐ Thyroid disease
- ☐ Artificial valves
- ☐ Diabetes
- ☐ Frequent headaches
- ☐ Hepatitis B or C
- ☐ Liver disease
- ☐ Psychiatric care
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis

Please list all other medical conditions:

____ ____

____ ____

Please list all current medications (prescribed or over the counter):

____ ____

____ ____

Women

Are you taking contraceptives or other hormones? . . . . . . Y N

Are you pregnant? . . . . Y N

If so, expected delivery date: ___________________________

Are you nursing? . . . . Y N

Are you allergic to any of the following?

Local anesthetics ("Novocain") . . . . Y N

Penicillin or other antibiotics . . . . Y N

Sulfa drugs . . . . Y N

Barbiturates, sedatives, or sleeping pills. . . . . Y N

Aspirin, Acetaminophen, or Ibuprofen. . . . . Y N

Codeine, Demerol, or other narcotics. . . . . Y N

Reaction to metals . . . . Y N

Latex or rubber dam . . . . Y N

Other: ____

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

____

Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Our office is HIPPA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.