PATIENT HISTORY & INFORMATION

Date: ______
Birth Date: ______
Age: ______ Sex: ______ Marital Status: ______

NAME MR. MRS. MISS: ______ LAST ______ FIRST ______ MIDDLE

ADDRESS (Home): ______ STREET ______ CITY ______ STATE/ZIP ______ Phone: ______

ADDRESS (Bus.): ______ STREET ______ CITY ______ STATE/ZIP ______ Phone: ______

Employer: ______ Occupation: ______ Social Security No.: ______

Spouse's Name: ______ Birthdate: ______ Age ______ Mr. ______ Mrs. ______ Miss ______ Ms ______

Spouse's Employer: ______ Occupation: ______ Years with firm/ ______

Employer's Address: ______ City: ______ Telephone: ______ Ext.: ______

Nearest Relative ______ Home Tel.:(____) ______

Not living with You ______ Work Tel.:(____) ______

PATIENT'S
Driver's License No.: ______ Whom may we thank for referring you to us? ______

If Patient is a Minor
Who is financially responsible for this bill? ______ Surname ______ First ______ Soc. Security # ______

Whom may we contact in case of emergency? ______ Phone: ______

Insurance company: ______ Policy No.: ______

In whose name is policy carried: ______ Insurance eligibility dates: ______ Medicare/Welfare No.: ______

How much is the deductible: ______ Other insurance coverage: ______

MEDICAL/DENTAL HISTORY –

Physicians's name: ______ Address/City/State: ______ Phone: ______

When did you last consult a physician? ______ Reason: ______

Have you been a patient in a hospital in the past 2 years: ☐ Yes ☐ No Reason: ______

Name of former dentist: ______ Date of last dental examination: ______

What is your immediate dental problem?: ______

HAVE YOU TESTED POSITIVE FOR THE HIV AIDS VIRUS? ☐ YES ☐ NO

Do you have, or have you had, any of the following *(Please check and describe fully under remarks)*:

	YES	NO
1. Heart Disease	☐	☐
2. High Blood Pressure	☐	☐
3. Blood Disease	☐	☐
4. Rheumatic Fever	☐	☐
5. Heart Murmur	☐	☐
6. Diabetes	☐	☐
7. Stroke	☐	☐
8. Epilepsy	☐	☐
9. Fainting	☐	☐
10. Psychiatric Treatment	☐	☐
11. Arthritis	☐	☐
12. Tumor History	☐	☐
14. Radiation Treatment	☐	☐
15. Liver or Kidney Disease	☐	☐
16. Hepatitis, Jaundice	☐	☐
17. Allergies		
a. Penicillin	☐	☐
b. Other Antibiotics	☐	☐
c. Local Anesthetic	☐	☐
d. Others	☐	☐
18. Asthma	☐	☐
19. Respiratory Disease	☐	☐
20. Does your jaw "click" or hurt?	☐	☐
21. Are you pregnant?	☐	☐
Have you had excessive bleeding requiring treatment?	☐	☐
Are you taking medicine, drugs or pills regularly?	☐	☐
Have you experienced any unfavorable reaction to previous dental treatment?	☐	☐

Remarks: ______

ACKNOWLEDGEMENT AND AUTHORITY –

This is my consent for the dentistry indicated on the examination chart. I also agree to the use of a local anesthetic and premedication or sedation by the inhalation or oral route, depending upon the judgment of the dentists involved in my case. I have been informed of all probable complications of the dentistry, anesthesia, premedication, sedation and other drugs.

I acknowledge full responsibility for the payment of such services and agree to pay for them, in full, **AT THE TIME OF SERVICE,** *unless other arrangements are made prior to the start of the services. I also understand that total payment of the fee for dental services by Dr. Baldwin Louie is my responsibility and not that of the insurance company. As a courtesy, insurance forms will be completed without charge.*

Signed: ______

PATIENT, PARENT OR AGENT (MUST BE 18 YEARS OR OLDER)