Patient's name (please print) ____**Date:** ________________

Welcome! We would like to make you feel comfortable and safe. If there is anything you need, please do not hesitate to ask. Our goal is to promote your oral health and help you to maintain your natural teeth in function as long as possible (when it makes sense to keep them.) If you have dental insurance, we will work with you to maximize your insurance benefits and make any remaining balance affordable. We offer discount for cash patient and several payment options to best meet the needs of your family which include all major credit cards, cash, check, and financing through *CareCredit®.*

Please take a few moments to fill out the following information as completely as possible:

PATIENT'S INFORMATION

Gender: M F Date of Birth (DOB)____________________Social Security Number (SSN):_______________________;

Home Address ____;

Phone (Home, Cell, Work) __________________________________; Email______________________________________;

Primary Language Spoken____________________________________; Can communicate in English. Yes No

Primary Insurance Company_________________________ Group #_______________ Subscriber____________________

Secondary Insurance Company_______________________ Group #_______________ Subscriber____________________

In case of emergency, contact ____________________________ Phone ____________________ Relationship ______________

Responsible Party (if different from above)

Name: ____SSN: _____________________; DOB_________________

Gender: M F ; Relationship to Patient________________; Phone (Home, Cell, Work) _______________________________

Home Address (if different from above): ____;

Employer____

I, the undersigned patient/guardian, certify that I (or my dependent) have insurance coverage as written above, and authorize payment directly to Huan Lu, DDS, PhD/Family Dentistry, insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all costs of dental treatment whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers. I authorize this office to bill me for the services rendered.

Signed____ Date_________________________

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

CONSENT

I understand that honest answers to the questions stated below are important to the provision of my dental care, and I will answer them to the best of my ability. I understand that if I am uncertain about the question or how the question relates to my health status, I can discuss the problem with the doctor or a member of the office staff. I understand that all questions must be answered. I understand that the information I provide will not be released without my express permission. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to other health professionals.

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor. I have read and understood the above and voluntarily consent to care.

Signature____Date______________ Relationship to Patient _____________

How did you hear about us?_ ____

Whom may we thank for referring you?____

Patient's name (please print) ____**Date:** ________________

DENTAL HISTORY

Reason for today's visit

____

Date of last dental exam __________; Name of previous dentist ___________________________; Phone ____________________

Which statement best reflects you?

_ I have an emergency (or I have pain) and want immediate relief or assistance.

_ I would like a traditional cleaning and exam and may be interested in understanding my oral health.

_ I value my teeth and would like to keep them for a lifetime, but would like to proceed slowly.

_ I have dental problems, wish to retain my teeth for a lifetime, and would like to correct these problems ASAP.

_ Other. Please specify ____

How would you describe your anxiety level?

_ I am not nervous. I have had good dental experiences in the past.

_ I am a little anxious. After all, I am at the dentist's office.

_ I am very worried. It is difficult for me to be here.

	Yes	**No**		**Yes**	**No**
1.Do your gums bleed when brushing or flossing?	( )	( )	8.Do you have frequent headaches?.	.( )	( )
2.Are your teeth sensitive to hot or cold?	( )	( )	9.Do you clench or grind your teeth?	.( )	( )
3.Are your teeth sensitive to sweet or sour?	( )	( )	10.Do you bite your lips or cheeks frequently?.	( )	( )
4.Do you feel pain to any of your teeth?	( )	( )	11.Have you ever had any difficult extractions?	( )	( )
5.Do you have any sores or bumps in/near your mouth?	( )	( )			
6.Have you had any head, neck or jaw injuries?	( )	( )	12.Haveyou had any orthodontic treatment?	( )	( )
7.Have you ever experienced any of the following In your joints?			13.Do you wear dentures or partials?	.( )	( )
If yes, how long?________________________			14.Have you ever seen a periodontist?	( )	( )
Clicking……………………………………………………………	( )	( )	15. Do you smoke?	( )	( )
Pain (joint, ear,side of face) upon opening……..	( )	( )	16. Do you use smokeless tobacco?	( )	( )
Difficulty in opening or closing…………………………	( )	( )			
Difficulty in chewing………………………………………	( )	( )			

17. Have you ever had difficult extraction or any prolonged bleeding following extraction? ..( ) ( )

MEDICAL HISTORY

1. Are you currently under the care of a physician, or has a physician ever advised you to take pre-medication prior to dental care? Yes No If yes, please explain ____

2. Have you ever been hospitalized for any surgical operation or serious illness? Yes No

If yes, please explain ____

____

3. Are you allergic to or have you had any reactions to the following? (please check all that apply)

( ) Aspirin

( ) Barbiturates

( ) Codeine or Hydrocodone

( ) Latex

( ) Other (please list)____________________________

( ) Local Anesthetic (i.e. Lidocaine)

( ) Metals (i.e. Nickel, Mercury etc)

( ) Penicillin or Other Antibiotics

( ) Sulfa Drugs

4. DO YOU HAVE ANY OF THE FOLLOWING? Please check all that apply.

( ) AIDS/HIV positive ( ) fainting or dizziness ( ) radiation treatment

Patient's name (please print) ____**Date:** ________________

( ) anemia	( ) glaucoma	( ) respiratory disease
( ) angina	( ) headaches	( ) scarlet fever
( ) arthritis/rheumatism	( ) heart problems	( ) sinus trouble
( ) asthma	( ) hepatitis type_______	( ) skin rash
( ) back problems	( ) herpes	( ) special diet/weight loss
( ) cancer	( ) hypertension	( ) stroke
( ) chemical dependency	( ) jaundice	( ) swollen feet/ankles
( ) chemotherapy	( ) kidney disease	( ) swollen neck glands
( ) circulatory problems	( ) liver disease	( ) thyroid problems
( ) cortisone treatments	( ) low blood pressure	( ) tonsillitis
( ) cough, persistent or bloody	( ) nervous problems	( ) tuberculosis
( ) diabetes; type ______	( ) pelvic inflammatory disease	( ) tumors
( ) emphysema	( ) PPD positive	( ) ulcer
( ) epilepsy	( ) psychiatric care	( ) venereal disease

Do you need to take antibiotics for prophylaxis? Yes   No   Patients with heart or valvular defects, stents, prosthetic joints, or a history of taking fen-phen diet pills should take antibiotics before having a dental procedure to minimize bacterial endocarditic or other infections.

Do you have or have you had any other diseases or medical problems NOT listed on this form? (please specify if yes)

____

Pharmacy Phone Number ____

For Women Only:

(   ) using contraceptive medication?   (   ) Pregnant? _______months   (   ) nursing?

I understand that should there be a change in my health during my dental treatment, I am to inform the dentist at the earliest possible time.

____   ____________________

Signature of Patient or Legal Guardian   Date

Reviewed and discussed with the patient by Dr.___________, Date _______________________

Comments/Significant findings on patient interview concerning medical history:____

____

____

Dental management considerations:____

____

____