PATIENT HISTORY AND INFORMATION

Today's Date: ____________________

Birth Date: ______________ Social Security No.: ______________________ Email: _______________________

Name: ____ Age: _____ Sex: _____ Marital Status: ___________
last first middle

Address: ____ Duration: ____ Home #: ______-________________
(home) street city state zip

Address: ____ Duration: ____ Work #: ______-________________
(work) street city state zip

Employer: ____ Occupation: __________________________ Cell #: ______-________________

For full time student, number of units currently enrolled: ______ units. School: _______________________________ F / W / S Semester. Year: _________

Emergency Contact Phone: __________________________

Whom may we thank for referring you to our office? ____ or: Google [ ], Yelp [ ], huidental.com [ ], Signage [ ]

IF YOU HAVE DENTAL INSURANCES, PLEASE COMPLETE THE FOLLOWING:

Our office will assist you in billing your insurance company. However, you are the party responsible for any payment due, not your insurance company.

Insured Person: Patient [], Spouse [], Parent [], Birthdate:_____-_____-_____

Subscriber: ______________________ SSN #: _____-_____-________

Employer: ______________________ Phone: _____-______________

Address: ____

Insurance Company: __________________________________

Group #: ________________________ Union Local: _______________

Insurance Company's Phone #: __________________________

Insured Person: Patient [], Spouse [], Parent [], Birthdate:_____-_____-_____

Subscriber: ______________________ SSN #: _____-_____-________

Employer: ______________________ Phone: _____-______________

Address: ____

Insurance Company: __________________________________

Group #: ________________________ Union Local: _______________

Insurance Company's Phone #: __________________________

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

Person Responsible for Payment:

Name: ________________________________ Relationship: ______________ Birth Date: _________________ SSN: _______-______-____________

Home Address: ____ Home Phone: _____________________

Employer: ____ Occupation: _______________________ Work Phone: _____________________

DENTAL HISTORY:

Name of former dentist: ____ Date of last dental visit: ______________________

Address of former dentist: ____ Phone: _________________________________

Reason for Today's Visit: ____

© Hui Dental 12.2015

MEDICAL HISTORY

Physician's Name: ______________________ Address: ______________________ Tel: ______-______-______

If you have been hospitalized during the past 5 years, please explain: ______________________

	yes	no
Is your general health good?	[]	[]
Has there been a change in your health within the last year?	[]	[]
Have you been hospitalized or had a serious illness within the last three years? If yes, why? ______________	[]	[]
Are you treated by a physician now? For what? ______________	[]	[]
Date of last medical exam_ ______________		
Allergies to: drugs, foods, medications, latex, penicillin	[]	[]
Are you in pain now?	[]	[]
Chest pain (angina)	[]	[]
Swollen ankles	[]	[]
Shortness of breath	[]	[]
Recent weight loss, fever, night sweats	[]	[]
Persistent cough, coughing up blood	[]	[]
Bleeding problems, bruising easily	[]	[]
Sinus problems	[]	[]
Difficulty swallowing	[]	[]
Diarrhea, constipation, blood in stools	[]	[]
Frequent vomiting, nausea	[]	[]
Difficulty urinating, blood in urine	[]	[]
Excessive thirst, frequent urination, dry mouth	[]	[]
Diabetes	[]	[]
AIDS	[]	[]
Recreational drugs	[]	[]
Over the counter medicine, natural remedies	[]	[]

	yes	no
Heart disease	[]	[]
Heart attack, heart defects	[]	[]
Heart murmurs	[]	[]
Rheumatic fever	[]	[]
Stroke, hardening of arteries	[]	[]
High blood pressure	[]	[]
Prosthetic heart valve	[]	[]
Pacemaker, implanted defibrillator	[]	[]
Asthma, TB, emphysema, other lung diseases	[]	[]
Hepatitis, other liver disease	[]	[]
Stomach problems, ulcers	[]	[]
Psychiatric care	[]	[]
Radiation treatments	[]	[]
Chemotherapy	[]	[]
Artificial joint	[]	[]
Dizziness, ringing in the ear, headache, fainting spells	[]	[]
VD (syphilis or gonorrhea), herpes	[]	[]
Kidney, bladder disease	[]	[]
Have you taken Fosamax, Aredia, Zometa, Bondronat, Actonel	[]	[]
Skin disease, eye disease	[]	[]
Thyroid, adrenal disease	[]	[]
Tobacco in any form	[]	[]
Alcohol	[]	[]
Surgeries, blood transfusions	[]	[]
Are you or could you be pregnant or nursing?	[]	[]
Any medical problems not listed on this form	[]	[]

List all medications you are taking including aspirin, vitamins, etc: ______________________

Please describe any unfavorable dental experience you have had: ______________________

If you require pre-medication, such as antibiotics or sedatives, prior to dental treatment, please list them: ______________________

____

ACKNOWLEDGEMENT AND CONSENT

I consent to the treatment as necessary for the patient named above, including but not limited to any medications such as anesthetics, analgesics, antibiotics, antiseptics, x-rays, laboratory work that may be used, dispensed, or prescribed by the attending doctor, or his assistants. I authorized the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my children to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I also acknowledge full responsibility for the payment of such services and agree to pay in full the portion not covered by my insurance, at the time of service, unless financial agreement is made prior to service. Unless I have prepaid for my services prior to treatment, the Hui Dental Group may request a credit report on me and/or my guarantor.

Signature: ______________________ Date: ______________

patient, parent, or guarantor (must be 18 or older)

THERE IS NO CHANGE TO MY MEDICAL HISTORY AS STATED ABOVE:

Date: __________ Initial: _____ Date: __________ Initial: _____ Date: __________ Initial: _____

Date: __________ Initial: _____ Date: __________ Initial: _____

© Hui Dental 12.2015