Tao Sun DDS

Please answer these questions. Feel free to ask us any questions you may have.

Today's Date: ___/___/___

About You

Patient Name:

(Last Name):_____(First Name)_____ (MI):_____ (Preferred Name):_____

☐Male ☐ Female Birthdate:___/____/____ Age:_____ SS#: ____-___-_____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____ Work Phone: ( )_____-_____

Email Address:_____ Refeerred By:_____

Status: ☐Minor ☐Single ☐Married ☐ Divorced ☐Separated ☐Widowed

Spouse's Name:_____ Do you have children? ☐Yes ☐No If Yes, how many?_____

Would you like to add your family to our records?

Name: _____ Age:_____

Name: _____ Age:_____

Name: _____ Age:_____

Insurance Information

Primary Dental Insurance: Company Name:_____ Phone # : ( )_____-_____

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

Insured's Name:_____ Relation: _____ Birthdate:___/____/____

Group #: _____ Insured's SS#:_____-_____-_____ Insured's Employer: _____

Secondary Dental Insurance: Company Name:_____ Phone # : ( )_____-_____

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

Insured's Name:_____ Relation: _____ Birthdate:___/____/____

Group #: _____ Insured's SS#:_____-_____-_____ Insured's Employer: _____

Account Information

Person ultimately responsible for account:

Name: _____ Relation: _____

Billing Address: _____ City: _____State:_____ Zip: _____

SS#:_____-____-_____ Driver's License#:_____ Work Phone: ( )_____-_____

_____(Initals): I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

In event of an emergency

Whom should we contact?: _____ Relation:_____

Home Phone: ( )_____-_____Cell Phone:( )_____-_____Work Phone: ( )_____-_____

Who is your Medical Doctor?:_____ Medical Doctor's Phone: ( )_____-_____

Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Are you in pain? ☐ No ☐ Yes If yes, for how long?_____

Please Indicate ☑ any of the following problems:

☐ Discomfort, Clicking, Popping of jaw ☐ Lost/Broken Filling(s) ☐ Stained Teeth ☐ Red, Swollen, Bleeding gums

☐ Teeth Grinding ☐ Ringing Ears ☐ Sensitive tooth/teeth, or gums ☐ Bad Breath

☐ Blisters/Sores in or around mouth ☐ Broken/Chipped teeth ☐ Locking jaw ☐ Other:_____

Do you require Pre-Medication? ☐ Yes ☐ No ☐ I'm not sure

Previous Dentist: _____ Phone Number: ( )_____-_____

Last Dental Exam: ___/____/____ Last X-Rays: ___/____/____

How many times a day do you brush? _____ How many times a week do you floss? _____

What type of tooth bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? ☹ 1 2 3 4 5 6 7 8 9 10 ☺

Medical History

Are you taking any of the following medications? No ☐ Yes ☐

☐ Nerve pills ☐ Pain Killers (including asprin) ☐ Muscle Relaxers ☐ Stimulents ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Other(s) please list: _____

Are you allergic to any of the following?

☐ Latex ☐ Penicillin/ Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics ☐ Other(s):_____

Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No

Do you use tobacco? ☐ No ☐ Yes/How used? _____ How much? _____ How Long? _____

For Women: Are you taking birth control? ☐ Yes ☐ No Are you pregnant? ☐ No ☐ Yes/How long? _____

Are you nursing? ☐ Yes ☐ No Do you have children? ☐ No ☐ Yes/ How many?_____

Do you wear contact lenses? ☐ Yes ☐ No How do you rate your health from 1-10? _____

Do you have any of the following diseases, medical conditions, or procedures?

Y – N Heart Attack/ Stroke	Y – N Heart Diseases	Y – N Thyroid Problems	Y – N Stomach Problems
Y – N Heart Sur/Pacemaker	Y – N Congenital Heart Defect	Y – N Kidney Problems	Y – N Psychiatric Problems
Y – N Heart Murmur	Y – N Chest Pains	Y – N Liver Problems	Y – N Venereal Diseases
Y – N Rheumatic Fever	Y – N Scarlet Fever	Y – N Respiratory Problems	Y – N Alcohol/Drug Abuse
Y – N Mitral Valves	Y – N Nervousness	Y – N Sinus Problems	Y – N Tuberculosis
Y – N Jaw Problems TMJ/TMD	Y – N Artificial Bones/Joints	Y – N Cosmetic Surgery	Y – N High/Low BP
Y – N Cancers/Tumors	Y – N Emphysema	Y – N X-ray/Cobalt Tx	Y – N Bleeding Problems
Y – N Shingles	Y – N Fainting/Seizers/Epilepsy	Y – N Chemotherapy	Y – N Glaucoma
Y – N Hepatitis	Y – N Frequent Headaches	Y – N Asthma	Y – N Anemia
Y – N HIV+/AIDS/ARC	Y – N Frequent Neck Pain	Y – N Difficult Breathing	Y – N Leukemia
Y – N Arthritis/Rheumatism	Y – N Back Problems	Y – N Diabetes	Y – N Hypoglycemia

WE INVITE YOU TO DISCUSS WITH US QUESTIONS REGARDING OUR SERVICES. THE BEST DENTAL HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT.

OUR POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS MANAGER. IF ACCOUNT IS NOT PAID FOR WITHIN 90 DAYS OF DAYS OF THE DATE OF SERVICE AND IF NO FINANCIAL ARRANGEMENTS HAVE BEEN MADE, YOU WILL BE RESPONSIBLE FOR LEGAL FEES, COLLECTION AGENCY FEES, INTEREST CHARGES, AND ANY OTHER EXPENSES INCURRED IN COLLECTING YOUR ACCOUNT. _____ (initial)

I AUTHORIZE THE STAFF TO PERFORM ANY NECESSARY SERVICES NEEDED DURING DIAGNOSIS AND TREATMENT. I ALSO AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS._____ (initial)

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician.

Patient Signature: _____

Date: ___/_____/_____

Physicians Name: _____

Physician's Number: ( ) _____-_____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS FORM. TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH AND/OR MEDICATION. FURTHER, I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS/HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____