About You

Name: ______________________________ Name Preference: ____________
Last First MI

Birth Date: __________ ❑ M ❑ F Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Other

Address: ______________________________ City/State/Zip: ____________

Home #: ____________ Cell #: ____________ Carrier: ____________

Work #: ____________ Ext: ______ Whom may we thank for referring you? ____________

Whom should we contact in case of an emergency: ____________

Relation: ____________

Home #: ____________ Cell #: ____________ Work# ____________ Ext: ______

Insurance Information

Person Responsible for this Account:

Name: ______________________________ Relationship to patient: ________ Birth Date: ________
Last First MI

Address (if different from patient): ____________ City/State/Zip ____________

Home #: ____________ Cell #: ____________ Carrier: ____________

Work #: ____________ Ext: ______ Employed by: ____________

Business Address: ____________ City/State/Zip: ____________

Insurance Company: ____________ Insurance Phone: ____________

Insurance Address: ____________ City/State/Zip: ____________

Group # (plan, local, or policy#): ____________ Other dependents under this plan ____________

Does the patient have a secondary insurance plan? ❑ Yes ❑ No Insured's Name: ____________

Relation to Patient: ____________ Birth Date: ____________

Insurance Company: ____________ Insurance Phone: ____________

Insurance Address: ____________ City/State/Zip: ____________

Group # (plan, local, or policy#): ____________

Social Security Number: ____________ Date of Birth: ____________

E-Mail Address: ____________ Occupation: ____________

Dental History

Reason for today's visit: ____________

Are you in pain? ❑ Yes ❑ No How long? ____________

Please check yes or no if any of the following applies:

❑ Y ❑ N Discomfort, clicking, popping, or locking of jaw
❑ Y ❑ N Sensitivity of teeth/gum to cold/heat/sweets when biting
❑ Y ❑ N Bad breath
❑ Y ❑ N Dry mouth
❑ Y ❑ N Orthodontic treatment
❑ Y ❑ N Gag easily
❑ Y ❑ N Grinding/clenching teeth
❑ Y ❑ N Jaw pain (TMJ/TMD)
❑ Y ❑ N Blisters/sores on lips/mouth
❑ Y ❑ N Growth on lip or in mouth
❑ Y ❑ N Mouth breathing
❑ Y ❑ N Food collecting between teeth
❑ Y ❑ N Periodontal (gum) disease
❑ Y ❑ N Lip/Tongue piercing
❑ Y ❑ N Lip or cheek biting
❑ Y ❑ N Red/swollen/bleeding gums
❑ Y ❑ N Lost/broken filling or loose teeth
❑ Y ❑ N Need to chew on one side of mouth
❑ Y ❑ N Wear full/partial dentures
❑ Y ❑ N Other: ____________

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know Name of medication: ____________

Former Dentist: ____________ Last Dental Visit: ____________ Last Dental X-Rays: ____________

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Medical History

General health (please check): ☐ Excellent ☐ Good ☐ Fair ☐ Poor Date of last physical: ____________

Do you smoke or use tobacco? ☐ Yes ☐ No If yes, how often? ____________

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please explain: ____________

Are you currently under physician care? ☐ Yes ☐ No If yes, please explain: ____________

Date of last visit: ____________ Physician's Name/Phone #: ____________

Please check yes or no if any of the following applies:

☐ Y ☐ N Heart Murmur
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Artificial Heart Valves
☐ Y ☐ N Artificial Joints
☐ Y ☐ N Arthritis, Rheumatoid
☐ Y ☐ N Cosmetic Surgery/Implants
☐ Y ☐ N Congenital Heart Defects
☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Hepatitis, Type
☐ Y ☐ N Stroke
☐ Y ☐ N Cancer
☐ Y ☐ N Leukemia
☐ Y ☐ N Anemia
☐ Y ☐ N Radiation Treatment
☐ Y ☐ N Tumor or Growth
☐ Y ☐ N Chemotherapy

☐ Y ☐ N Abnormal Bleeding
☐ Y ☐ N On Coumadin/Plavix
☐ Y ☐ N Respiratory Disease
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Asthma
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Persistent Cough
☐ Y ☐ N Pacemaker/Heart Surgery
☐ Y ☐ N Heart Problems
Describe ____________
____
☐ Y ☐ N Diabetes
☐ Y ☐ N Kidney Disease
☐ Y ☐ N Liver Disease
☐ Y ☐ N Chemical Dependency
☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Low Blood Pressure

☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Cortisone Treatment
☐ Y ☐ N Rapid Weight Gain/Loss
☐ Y ☐ N Severe/Frequent Headaches
☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Nervousness
☐ Y ☐ N Tobacco Habit
☐ Y ☐ N Alcohol Dependency
☐ Y ☐ N Circulatory Problems
☐ Y ☐ N Stomach Ulcer
☐ Y ☐ N Back Problems
☐ Y ☐ N Glaucoma
☐ Y ☐ N Anaphylaxis
☐ Y ☐ N Skin Rash
☐ Y ☐ N Epilepsy
☐ Y ☐ N Other ____________
____

Women: Are you pregnant? ☐ Y ☐ N Due date: ____________ Nursing? ☐ Y ☐ N
Taking Birth Control Pill? ☐ Y ☐ N Type: ____________

Allergies: ☐ Latex ☐ Anesthetics ☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Metal ☐ Food ☐ Pollen
☐ Other, please list: ____________

Medication: Please list all medications you are currently taking and the correlating diagnoses: ____________

____

Signature of Patient, Parent or Guardian: ____________ Date: ____________

Relationship to Patient: ____________

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My Smile Profile

Patient Name: ______________________________ Date: ______________

Please take a few minutes to let us know your smile a little bit better and how we could help make it even more beautiful by answering the following questions:

Are you satisfied with the appearance and functions of your teeth? ❑ Yes ❑ No

Please comment: ______________________________

Would you like your smile to be better, brighter, or different? ❑ Yes ❑ No

Please comment: ______________________________

If you had a magic wand and could change anything, you wanted about your smile, what would it be?

____

Would you like to keep all of your teeth your whole life?

____

Please check below any changes you would make in your smile:

❑ Whiten all visible front teeth
❑ Whiten a single tooth
❑ Close spaces between teeth
❑ Straighten teeth
❑ Lengthen teeth
❑ Shorten teeth
❑ Rebuild chipped teeth
❑ Repair uneven edges
❑ Eliminate crowding
❑ Eliminate dark or stained fillings
❑ Reduce gum showing in smile
❑ Repair gum recession

Please help us make your visit more pleasant by answering the following questions:

Have you ever had an upsetting dental experience? ❑ Yes ❑ No

If yes, please describe: ______________________________

Do you feel nervous about having dental treatment done? ❑ Yes ❑ No

If so, what is your biggest concern? ______________________________

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Irwan Goh, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgement.)

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please print your name (Parent/Guardian)

______________________________ ______________________
Parent/Guardian signature Date

____
Patient's Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibit obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) ______________________________

Staff Signature: ______________________________ Date: ______________