WELCOME

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The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you. All information will remain secure and confidential.

1. ABOUT YOU

Today's Date:

Name:
(Last) (First)

Prefer to be called: Male ☐ Female ☐

Birth date:

SS#: DL#:

Home address: Apt:

(City) (State) (Zip)

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

HM#: Cell/Other#:

WK#: Ext#:

E-mail:

Employer:

Employer's address:

(City) (State) (Zip)

How long there? Occupation:

Where and when are the best times to reach you?

Who may we thank for referring you?

Other family members seen by us?

Previous / Present Dentist:
(Please Circle)

Last visit date:

2. SPOUSE INFORMATION

Name:
(Last) (First)

Employer:

SS#: DL#:

Birth date:

HM#: Cell/Other#:

WK#: Ext#:

Person Responsible for Account:

HM#: Cell/Other#:

WK#: Ext#:

Billing address: Apt:

(City) (State) (Zip)

Relationship: SS#:

Employer: DL#:

3. DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. name:

Insurance Co. address:

(City) (State) (Zip)

Insurance Co. phone:

Group# (Plan, Local, or Policy#):

Insured's name: Relationship:

Insured's birthday: Insured's SS#/ID#:

Insured's employer:

Secondary Dental Insurance

Insurance Co. name:

Insurance Co. address:

(City) (State) (Zip)

Insurance Co. phone:

Group# (Plan, Local or Policy#):

Insured's name: Relationship:

Insured's birthday: Insured's SS#/ID#:

Insured's employer:

4. MEDICAL HISTORY

In the event of an emergency, is there someone who lives near you that we should contact?

Names: Relationship:

WK#: HM#: Cell/Other#:

Do you have a personal physician? Yes ☐ No ☐

Physician's name:

Phone: Date of last visit:

Your current physical health is: Good ☐ Fair ☐ Poor ☐

Are you currently under the care of a physician? Yes ☐ No ☐

Please explain:

Are you taking any prescription / over-the-counter drug? Yes ☐ No ☐

Please list each one:

FOR WOMEN

Are you taking birth control pills? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐ Week(s):

Are you nursing? Yes ☐ No ☐

CONTINUED ON BACK

4. MEDICAL HISTORY (CONT'D)

Have you had any of the following diseases or medical problems? (cirle & dates)

	(When)		(When)
Heart Attack / Stroke		Psychiatric Problems	
Cancer / Chemotherapy		Epilepsy / Seizures / Fainting Spells	
Heart Murmur		Diabetes I / II	
Rheumatic Fever		Drug / Alcohol Abuse	
HIV+ / AIDS		Venereal Disease	
Heart Surgery / Pacemaker		Hemophilia / Abnormal Bleeding	
Shingles		Ulcers / Colitis	
Mitral Valve Prolapse		Congenital Heart Defect	
Kidney Problems		Anemia / Radiation Treatment	
Artificial Bones / Joints		Asthma / Arthritis	
Artificial Valves		Difficulty Breathing	
Sinus Problems		Hospitalization for Any Reason	
High / Low Blood Pressure		Hepatitis A / B / C	
Fever Blisters		Blood Transfusion	
Severe / Frequent Headaches		Emphysema / Glaucoma	
Bisphosphonate (Fosamax) treatment		Tuberculosis (TB)	

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs? (cirle)

Penicillin	Tetracycline	Latex
Aspirin	Dental Anesthetics	Other
Erythromycin	Codeine	

Please list any other drugs that you are allergic to:

our office is committed to meeting or exceedig the standards of HIPPA privacy act and infection control mandated by OSHA, the CDC and the ADA.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

THERE IS A $25.00 CHARGE PER 15 MINUTES SCHEDULED FOR ALL BROKEN APPOINTMENTS WITHOUT THE COURTESY OF 24 HOURS NOTICE.

PLEASE INITIAL HERE:

5. DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? Yes ☐ No ☐

Have you ever had serious / difficult problem associated with any previous dental work? Yes ☐ No ☐

Do you now or have you ever experienced pain / discomfort in your jaw joint? (TMJ / TMD) Yes ☐ No ☐

Your current dental health is: Good ☐ Fair ☐ Poor ☐

Do you like your smile? Yes ☐ No ☐

Do your gums ever bleed? Yes ☐ No ☐

How many times a week do you floss?

How many times a day do you brush?

Type of bristles? Hard ☐ Medium ☐ Soft ☐

6. TERMS AND CONDITIONS

I understand that I will be notified of all charges before treatment begins. Our practice depends upon your payment for the services rendered so we can pay our bills.

I understand that arrangements for payment must be made before dental treatment begins; and that I am directly financially responsible for all dental services.

Dental Insurance: Our office will assist you in verifying your benefits and collecting from your dental insurance. However, the portion your insurance does not pay is your responsibility. We can estimate what your insurance will pay. Any differences in payment will be your responsibility.

Assignment of Insurance: I authorize the release of any information relative to all claims. I hereby authorize my insurance company to pay directly to Julia H. Wu-Fang, D.D.S., Inc. any benefits for services rendered. I understand that any insurance checks sent to me are owed to Julia H. Wu-Fang, D.D.S., Inc. and I will bring them in immediately if I receive them.

Interest and Late Charges: Accounts are charged 1.5% per month interest if not paid in full after 45 days. A late fee of $10.00 is charged for all payments 30 days late.

In consideration of the professional services render to me by Dr. Fang, or her staff, I agree to pay Julia H. Wu-Fang, D.D.S., Inc. or its assignee, at the time services are rendered and/or follow any payment arrangements.

I understand that if my account becomes delinquent that it will be turned over to American Collection Agency and a negative credit rating will appear on my credit report. This could affect my ability to get a loan in the future.

I grant permission to you or your assigns to telephone me at work to discuss matters related to this form.

I have read the above conditions and agree to their content.

Signed: **Date:**

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. **Initials:** **Date:**

Doctor's Comments:

1. Date:	**Comments:**	**Signature:**
2. Date:	**Comments:**	**Signature:**
3. Date:	**Comments:**	**Signature:**