CONFIDENTIAL PATIENT INFORMATION

PATIENT'S NAME Last First Middle	DATE OF BIRTH (MM/DD/YY)	Gender ☐ F ☐ M

PATIENT'S ADDRESS	Home Phone #	Cell phone #	Work Phone #
	By which way do you prefer to communicate with us? (Check more than one choices if necessary) ☐ Home # ☐ Cell # ☐ Work # ☐ Text ☐ Email		

MARITAL STATUS	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

EMAIL ADDRESS (Your email address will be in confidence and only used for office communication with you)

SPOUSE'S NAME Last First Middle	SPOUSE'S EMPLOYER	OCCUPATION

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME: **RELATIONSHIP:** **WORK NO.** **HOME NO.**

HOW DID YOU HEAR ABOUT US?

☐ **FRIENDS/FAMILY (Please Name so we can thank them :_____)** ☐ **Internet (Website, facebook)** ☐ **Drive- By**

☐ **Phonebook (please name if known: _____)** ☐ **Newspaper (please name if known: _____)**

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE/COMMONLAW ☐ DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)

Group Number AND ID Number	EMPLOYER	EMPLOYER'S ADDRESS

SECONDARY INURANCE COVERAGE ☐ YES ☐ NO	2nd INSURANCE COMPANY NAME	2nd INSURANCE ADDRESS

SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE/COMMONLAW ☐ DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)

GROUP/PROGRAM NUMBER	EMPLOYER (If different from above)	EMPLOYER'S ADDRESS

I authorize Dr. Rhee to submit any necessary pre-determinations inquiring further information about my dental benefits for recommended treatments. Yes_____ No _____

GENERAL RELEASE

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answers to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers many specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the responsibility for payment of the dental services for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **24 hour** notification to avoid any minimum charges.

Patient's or Guardian's Signature _____ **Date** _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy, immunosuppressive _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. excessive alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Office Use Only: Blood Pressure: ____ / ____ Pulse: ____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth crowding or developing spaces? _____	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
28. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
30. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
32. Have you ever whitened (bleached) your teeth? _____	☐	☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
34 Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____