New Patient Registration

Li Chou DDS
Cosmetic & Family Dentistry

Dental History

Please circle the correct response:

Are any of your teeth sensitive to:
Hot or cold? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do your gums bleed or hurt? Yes No

Do you have any of the following: Dentures, fixed bridge, removable bridge? Yes No

Have you noticed any loose teeth? Yes No

Have you experienced clicking or popping? Yes No

Does food tend to get caught between your teeth? Yes No

Have you experienced pain? Yes No

Have you had difficulty chewing? Yes No

Do you suffer from dry mouth? Yes No

Do you clench or grind your teeth? Yes No

Do you smoke or chew tobacco? Yes No

Allergies:
Please circle if your response

Aspirin	Latex
Penicillin	Codeine
Iodine	Sulfa
Local Anesthesia	

If you are allergic to something else please list others:

Today's Date Account #

Patient Information

Name ____ ☐ Male ☐ Female
First Last Initial

Date of Birth | Social Security Number | Marital Status

Address | Apt#

City | State | Zip Code

Home Phone# | Work Phone# | Cell Phone #

Emergency Contact Name | Emergency Contact #

Primary Dental Insurance

Employee Name | Date of Birth

Employee Social Security Number | Relationship to Patient

Employer Name | Insurance Name

Group Number & Member ID | Insurance Phone Number

Acknowledgement of Receipt of Privacy Notice:
I have been given the opportunity to read and review the Privacy Notice for this dental office. I understand that other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization.

Initial ________

Consent for Dental Treatment:
I hereby authorize doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. I agree to the use of anesthetic, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Initial __________

Consent to Financial Agreement:
Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsibly for any and all expenses incurred at this office, and I understand that payment is due at the time of service unless other arrangements have been made. I understand that this office does offer payment plans for extensive dental treatments which require more than 1 appointment to complete. I am aware that if I accept a payment plan any and all balances must be paid off before the last appointment or before the dental treatment is completed.

In the case that I have dental insurance I am aware and fully understand that in the event that my Dental Insurance does not pay in full the charges submitted by the Dentist I will be responsible for any and all balances relating to my dental treatment. I understand that my Dental Insurance is only a contract between myself, my employer and the insurance company and this dental office is not a party of that said contract, this dental office is not a contracted provider.

Initial __________

______________________________ ______________
Patients or Responsible Party's Signature Date

New Patient Registration

MEDICAL HISTORY

1. Have you been under the care of a medical doctor during the past two years?
   Yes No If yes, for what?
   ____
2. Have you taken any medication or drugs the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list the name and dosage:
   ____
   ____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No If yes, please list:
   ____
   ____
5. **Women**, are you **Pregnant**? Yes No If so how many months?________

Current Medical Provider Information

____
Physician's Name
____
Physician's Phone Number
____
Address
____
Address
____
City State Zip

6. Only Circle to indicate which of the following you have had, or have at present time.

Heart (surgery, disease, attack)	Stroke	Bruise Easily	Emphysema
Chest Pain	Diet (special/restricted)	Liver Disease	Chronic Cough
Congenital Heart Disease	Artificial Joints (hip/knee)	Yellow Jaundice	Tuberculosis
Heart Murmur	Kidney Trouble	Neurological Disorder	Asthma
High Blood Pressure	Hepatitis A or B	Epilepsy/Seizures	Hay Fever
Mitral Valve Prolapse	Venereal Disease	Fainting/Dizzy Spells	Latex Sensitivity
Artificial Heart Valve	A.I.D.S	Nervous/Anxious	Allergies or Hives
Heart Pacemaker	H.I.V. Positive	Psychiatric Care	Sinus Trouble
Rheumatic Fever	Cold Sores/Blisters	Ulcers	Radiation Therapy
Arthritis/Rheumatism	Blood Transfusion	Diabetes	Chemotherapy
Cortisone Medicine	Hemophilia	Thyroid Problems	Tumors
Swollen Ankles	Sickle Cell Disease	Glaucoma	Contact Lenses

7. Do you have or have you had any disease, condition, or problem not listed? Yes No
   ____

Medical History Acknowledgement:
I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, you may release such information to you. I will notify the dentist of any change in my health or medication.
Initial__________

Date: ______________________________

Patient/Guardian Name: ______________________________

Patient/Guardian Signature: ______________________________

Medical Alert
(office use only)