Alliance Dental and Orthodontics

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Whom May We Thank for Referring You? Friend/Relative (name):_____*S.F. Examiner*, *SF Weekly*, *Chinese Yellow Pages*, *Singtao Yellow Pages*, Direct Mail, Chinese TV, Chinese Radio, Internet Google / Yahoo / CitySearch, *Singtao Newspaper*, *World Journal*, *AT&T Pacific Bell Yellow Pages*, Postcard, Other_____

Getting To Know You

First Name_____ Last Name_____
Gender____ Birthdate _____ If the patient is a child, parent's name_____

Marital Status_____SS#_____
Street Address_____
City_____State_____Zip_____

Home Phone #_____Work #_____
Cell #_____Email Address_____
Employer /Address _____

Previous Dentist_____
Last Visit Date_____

Spouse's Information

Spouse's name_____Birthdate_____
SS#_____ Work #_____
Employer /Address _____

Emergency Information

Nearest Relative (not living with you)_____
Phone #_____Work #_____

Primary Dental Insurance

Insurance Company Name_____
Group Number_____

Insured's Name_____Relation_____
Insured's Birthdate_____ SS#_____
Contact Phone #: _____
Employer_____

Date Insurance Policy was Started_____

Secondary Dental Insurance

Insurance Company Name_____
Group Number_____

Insured's Name_____Relation_____
Insured's Birthdate_____SS#_____
Contact Phone #: _____
Employer_____

Date Insurance Policy was Started_____

CANCELLATION POLICY

We require 24 hours notification if you are going to miss your appointment. If you fail to give us this notice, we will charge your account a fee of $50. **Patient's Initials**_____

Authorization

I authorize and give consent to the performance of dental services for myself or my dependent. I give consent to any necessary or advisable dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purposes or dental treatment. I understand that using anesthetic agents embodies certain risks. I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am finally responsible for payment of services rendered, regardless of insurance coverage.

Patient Signature _____ Date_____

I hereby acknowledge that I have received copies of the following notices: The Dental Board of California Dental Materials Fact Sheet, and the HIPPA Privacy Form 1 Notice of Privacy Practices.

Patient Signature_____ Date_____

Health History

I. **Circle Appropriate Answer**

II. Yes No Is your general health good?

1. Yes No Has there been a change in your health within the last year?
2. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
3. Yes No Are you being treated by a physician now? For what?_____
   Date of last medical exam_____
4. Yes No Have you had problems with prior dental treatment?
5. Yes No Are you in pain now?

II. Have you experienced:

1. yes	no	Chest pain(angina)	12. yes	no	Frequent vomiting, nausea
2. yes	no	Swollen ankles	13. yes	no	Difficulty urinating, blood in urine
3. yes	no	Shortness of breath	14. yes	no	Dizziness
4. yes	no	Recent weight loss, fever, night sweats?	15. yes	no	Ringing in ears
5. yes	no	Persistent cough, coughing up blood	16. yes	no	Headaches
6. yes	no	Bleeding problems, bruising easily	17. yes	no	Fainting spells
7. yes	no	Sinus problems	18. yes	no	Blurred vision
8. yes	no	Difficulty swallowing	19. yes	no	Seizures
9. yes	no	Diarrhea, constipation, blood in stools	20. yes	no	Joint pain, stiffness
10. yes	no	Excessive thirst	21. yes	no	Dry mouth
11. yes	no	Frequent urination	22. yes	no	Jaundice

III. **Do You Have or Have You Had**:

1. yes	no	Heart disease	17. yes	no	Thyroid, adrenal disease
2. yes	no	Stroke, hardening of arteries	18. yes	no	Heart attack, heart defects
3. yes	no	High blood pressure	19. yes	no	STD(syphilis or gonorrhea)
4. yes	no	Asthma, TB, emphysema, other lung diseases	20. yes	no	Kidney, bladder disease
5. yes	no	Hepatitis or other liver diseases	21. yes	no	Skin diseases
6. yes	no	Stomach problems, ulcers?	22. yes	no	Diabetes
7. yes	no	**Allergies to:** _____ drugs, foods, medication, latex	23. yes	no	Psychiatric care
8. yes	no	Family history of diabetes, heart problems	24. yes	no	Radiation treatment
9. yes	no	AIDS	25. yes	no	Herpes
10. yes	no	Cancer, tumors	26. yes	no	Anemia
11. yes	no	Arthritis, rheumatism	27. yes	no	Rheumatic fever
12. yes	no	Eye diseases	28. yes	no	Heart murmurs
13. yes	no	Prosthetic heart valve	29. yes	no	Artificial joint
14. yes	no	Hospitalization	30. yes	no	Blood transfusions
15. yes	no	Surgeries	31. yes	no	Pacemaker
16. yes	no	Contact lenses	32. yes	no	Chemotherapy

IV. **Are You Taking:**

1. yes	no	Recreational drugs	3. yes	no	Tobacco in any form
2. yes	no	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies	4. yes	no	Alcohol

Please list: _____
_____

V. **Women Only:**

1. yes	no	Are you or could you be pregnant or nursing	2. yes	no	Taking birth control pills

VI. **All Patients:**

1. yes no Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

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.

Patient's signature: _____ Date: _____

RECALL REVIEW:

1. Patient's signature _____ Date:_____
2. Patient's signature _____ Date:_____

3. Patient's signature ____ Date:___________________________