PATIENT INFORMATION

Date ______/______/_________ Sex ☐M ☐F Age _______ Date of Birth ______/______/_________

Patient Name ____ __________ ____
Last Name Middle Initial First Name

Address ____
Street City State Zip Code

☐Married ☐Widowed ☐Single ☐Minor ☐Separated ☐Divorced ☐Partnered for ________years

Home Phone (________) ____________________________ Work Phone (________) ___________________ Ext _________

Cell Phone (________) ______________________________ Spouse's Work Phone (________) ________________________

Email ____

Who is responsible for this account? __________________________________ Relationship to Patient _________________________

Patient Employer/School ____ Occupation _________________________________

Employer/School Address ____

Employer/School Phone (________) _____________________________

Spouse's Name _____________________________ Date of Birth ______/______/__________ SS# _______-______-________

Spouse's Employer ____

Whom may we thank for referring you? ____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household)

Name ____ Relationship ____

Home Phone (________) _________________________________ Work Phone (________) ______________________________

INSURANCE INFORMATION

Primary Insurance Company ____ Group # ______________________________

Subscriber _____________________________________ Date of Birth ______/______/_________ ID# _____________________

Relationship to Patient ____

Is patient covered by additional insurance? ☐Yes ☐No

Secondary Insurance Company ____ Group # ____________________________

Subscriber _____________________________________ Date of Birth ______/______/_________ ID# _____________________

Relationship to Patient ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to
Name of Insurance Company(ies)

Dr. Johwan J. Doh all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ____________________________________
Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient

____ ____________________________________
Please PRINT name of Patient, Parent, Guardian or Personal Representative Date

DENTAL INFORMATION

Reason for today's visit? ______________________________

Former Dentist ______________________ City and State ______________________

Date of last dental visit ______________________ Date of last dental X-rays ______________________

Please indicate if you have or have had any of the following:

- Bad Breath ☐
- Bleeding gums ☐
- Blisters on lips or mouth ☐
- Burning sensation on tongue ☐
- Chewing on one side of mouth ☐
- Cigarette, pipe, or cigar smoking ☐
- Clicking or popping jaw ☐
- Dry mouth ☐
- Fingernail biting ☐
- Food collection between teeth ☐
- Grinding teeth ☐
- Gums swollen or tender ☐
- Jaw pain or tiredness ☐
- Lip or cheek biting ☐
- Loose teeth or broken fillings ☐
- Mouth breathing ☐
- Mouth pain, brushing ☐
- Orthodontic treatment ☐
- Pain around ear ☐
- Periodontal treatment ☐
- Sensitivity to cold ☐
- Sensitivity to heat ☐
- Sensitivity to sweets ☐
- Sensitivity when biting ☐
- Sores or growth in mouth ☐

How often do you brush? ______________________ How often do you floss? ______________________

HEALTH HISTORY

Primary Care Physician ______________________ Date of last visit ______________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" these include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ☐ Yes ☐ No

Please indicate if you have or have had any of the following:

- AIDS/HIV ☐
- Anemia ☐
- Arthritis, Rheumatism ☐
- Artificial Heart Valves ☐
- Artificial Joints ☐
- Asthma ☐
- Back Problems ☐
- Bleeding abnormally, with extractions or surgery ☐
- Blood Disease ☐
- Cancer ☐
- Chemical Dependency ☐
- Chemotherapy ☐
- Circulatory Problems ☐
- Congenital Heart Lesions ☐
- Cortisone Treatments ☐
- Cough, persistent or bloody ☐
- Diabetes ☐
- Emphysema ☐
- Epilepsy ☐
- Fainting or dizziness ☐
- Glaucoma ☐
- Headaches ☐
- Heart Murmur ☐
- Heart Problems ☐
- Hepatitis Type __________ ☐
- Herpes ☐
- High Blood Pressure ☐
- Jaundice ☐
- Jaw Pain ☐
- Kidney Disease ☐
- Liver Disease ☐
- Low Blood Pressure ☐
- Mitral Valve Prolapse ☐
- Nervousness/Anxiety ☐
- Pacemaker ☐
- Psychiatric Care ☐
- Radiation Treatment ☐
- Respiratory Disease ☐
- Rheumatic Fever ☐
- Scarlet Fever ☐
- Shortness of Breath ☐
- Sinus Trouble ☐
- Skin Rash ☐
- Special Diet ☐
- Stroke ☐
- Swollen Feet or Ankles ☐
- Swollen Neck Glands ☐
- Thyroid Problems ☐
- Tonsillitis ☐
- Tuberculosis ☐
- Tumor or growth on head or neck ☐
- Ulcer ☐
- Venereal Disease ☐
- Weight Loss, unexplained ☐

Do you wear contact lenses? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Due Date ______________________

Are you nursing? ☐ Yes ☐ No Are your taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List ALL medications you are currently taking and the correlating diagnosis:

____

____

Pharmacy Name ______________________

Phone (__________) ______________________

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other ______________________

____

UPDATE

(TO BE COMPLETED AT FUTURE APPOINTMENT)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

If yes, for what conditions? ____

Are you taking any new medications? ☐ Yes ☐ No

If yes, what? ____

____

Patient Signature ____ Date ____________________

Doctor's Signature ____ Date ____________________

NOTES