

PATIENT INFORMATION

Jin Fu Li Family Dentistry

First Name: _____ MI: _____ Last Name: _____ Today's date: _____
 Sex: M F Date of Birth: _____ Age: _____ SS#: _____ Nickname: _____
 Address: _____ City: _____ State: _____ Zip: _____ E-mail: _____
 Home Phone: _____ Bus. Phone: _____ Cell Phone: _____
 Employer: _____ Referred By: _____
 Dentist: _____ Medical Dr. _____
 Driver's License: _____ Nearest relative not living with you: _____ Phone: _____
 Have you ever been a patient of our practice? Yes No Your Next Dental Appointment
 Method of Payment: Cash Check Credit Card Date: _____
 Do you belong to a PPO or HMO: Yes No Time: _____

PERSONAL INFORMATION

Marital Status: Married Divorced Legally Separated Widow Single
 Employment: NA Full-Time Part-Time Retired
 Student: NA Full-Time Part-Time School Name/Location: _____

RESPONSIBLE PARTY (if self, skip to the next section)

Self Spouse Father Mother Other Home Phone: _____
 Name: _____ SS#: _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ Phone: _____

SECONDARY RESPONSIBLE PARTY (if different from above)

Spouse Father Mother Other Home Phone: _____
 Name: _____ SS#: _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Employer: _____ Phone: _____

PRIMARY DENTAL INSURANCE COMPANY

Employer: _____
 Business Address: _____
 Phone: _____ Plan: _____
 Insurance Company: _____
 Group Name: _____
 Group #: _____
 Identification #: _____
 Primary Insured: _____
 Relationship to Primary Insured: _____

SECONDARY DENTAL INSURANCE COMPANY

Employer: _____
 Business Address: _____
 Phone: _____ Plan: _____
 Insurance Company: _____
 Group Name: _____
 Group #: _____
 Identification #: _____
 Primary Insured: _____
 Relationship to Primary Insured: _____

DENTAL INFORMATION

Reason for today's visit: Emergency Exam Schedule Procedure Consultation
 Are you in any pain? Yes No If yes, how long have you been in pain? _____
 Please indicate if you have any of the following problems by checking off the corresponding box:
Discomfort, Clicking or Jaw Popping Lost or Broken Filling(s) Stained Teeth
Red, Bleeding or Swollen Gums Teeth Grinding Locking Jaw
Sensitive Tooth or Gums Ringing Ears Bad Breath
Blisters/Sores in or Around the Mouth Broken/Chipped Tooth Other (please explain below)
 Other: _____
 Have you ever required pre-medication? Yes No Not Sure
 Previous dentist: _____ Phone: _____
 Last dental exam: _____ Last dental x-rays: _____
 How many times per day do you brush? _____ How many times per week do you floss? _____
 What type of toothbrush bristles do you use? Soft Medium Hard

MEDICAL HISTORY

Are you taking any of the following medications? Nerve Pills Pain Killers Muscle Relaxer
 Stimulants Blood Thinners Tranquilizers Insulin Other (list)
 Other medications: _____

Do you have or have had any of the following diseases, medical conditions or procedures? Please check proper box.

- | | | | |
|--|--|---|--|
| Y N | Y N | Y N | Y N |
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> X-ray or Cobalt Treatment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> HIV/AIDS/ARC | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Severe/Frequent Headache | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Glaucoma |

Are you currently or have you taken in the past (either orally or through IV) any of the following drugs:

- | | |
|--|---|
| Y N | Y N |
| <input type="checkbox"/> Actonel (Risedronate) for Osteoporosis | <input type="checkbox"/> Aredia (Pamidronate) for Cancer, Pagets |
| <input type="checkbox"/> Bonfos (Clondronate) for Cancer | <input type="checkbox"/> Boniva (ibandronate) Osteoporosis |
| <input type="checkbox"/> Didronel(Etidronate) Pagets | <input type="checkbox"/> Fosamax (Alendronate) Osteoporosis, Pagets |
| <input type="checkbox"/> Ostac (Clondronate) Cancer | <input type="checkbox"/> Skelid (Tiludronate) Pagets's |
| <input type="checkbox"/> Zometa (Zoledronic Acid) Osteoporosis, Cancer | |

MEDICAL HISTORY (continued)

List any other medical condition(s) you have or have had: _____

Are you allergic to the following? Latex Tetracycline Aspirin Dental Anesthetics
 Penicillin/Amoxicillin Not Sure Other (list)

Other Allergies: _____

Do you smoke? Yes No How many per day? _____ How long have you smoked? _____

Other tobacco products? Yes No What type of tobacco? _____ How often? _____ How long? _____

Please rate your general health 1-10: _____ Do you wear contact lenses? Yes No

Have you ever taken the drug Phen-fen or Redux Yes No

For women only:

Are you taking Birth Control pills? Yes No

How many children have you birthed? _____

Are you currently pregnant? Yes No If yes, how many months are you? _____

Are you nursing? Yes No

Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with our office. If the account is not paid in full of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____
 Adult Patient Parent or Guardian Spouse

**UPDATE
(Office Use Only)**

Initials _____ Date _____

Comments _____

Initials _____ Date _____

Comments _____

Initials _____ Date _____

Comments _____