Chua Dentistry New Patient Registration

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We are complimented that you have selected us to provide dental care for you and your family.

Whom may we thank for referring you to our office? _____

Patient Information

Date _____ Patient's Name _____
Last First Middle e-mail address
Address _____
Street City State Zip
Home Phone (____) ____-____ Work Phone (____) ____-____ Soc. Sec. # ____-____-____
Birthday ___/___/___ If patient is a minor, give parent's/guardian's name _____
Name of nearest relative not living with you _____ Relationship _____
Complete Address _____ Phone # (___) ____-____
Emergency Contact _____ Phone # (___) ____-____

Responsible Party Information

Name _____
Last First Middle Marital Status Relationship to patient
Residence _____
Street City State Zip
Mailing Address _____
Street City State Zip
How long at this address _____ Home Phone # (___) ____-____ Work Phone # (___) ____-____
Previous Address (if less than 3 years) _____
Street City State Zip
Social Security # ____-____-____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ # Years Employed _____
Employer Address _____
Spouse's Name _____ Relationship to Patient _____
Last First Middle
Employer _____ Occupation _____ No. Years Employed _____
Employer Address _____
Social Security # ____-____-____ Birthdate ____/____/____ Work Phone # (___) ____-____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # ____-____-____
Insured's Employer _____ Phone # (___) ____-____
Dental Insurance Company _____ Group # _____
Insurance Co. Address _____ Phone # (___) ____-____
Is policy connected with your union? Yes___ No___ Name of Union _____ Local # _____
Do you have dual coverage? Yes___ No___ If yes: Please complete the following secondary insurance information:
Insured's Name _____ Insured's Soc. Sec. # ____-____-____
Dental Insurance Co. _____ Group No. _____ Local # _____
Insurance Co. Address _____ Phone # (____) ____-____
Insured's Employer _____ Phone # (____) ____-____

Dental Information

Do your gums bleed when you brush? Yes ___ No ___
Are your teeth sensitive to heat or cold? Yes ___ No ___ Pressure Yes ___ No ___ Sweets Yes ___ No ___
Do you grind or clench your teeth? Yes ___ No ___
Do you have any fear of dental work? Yes ___ No ___
Date of last dental examination _____ What was done at the time? _____
Former Dentist Name _____ City _____
How would you describe your current dental problem? _____
How do you feel about the appearance of your teeth? _____

Medical Information

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? ..... YES NO
3. Are you now taking any medication (including vitamins, nutritional supplements and other over-the-counter products) ..... YES NO
   If yes, please list:_____
4. Have you taken any medication or drugs during the past two years including appetite suppressants – fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine?..... YES NO
5. Have you been under the care of a medical doctor during the past 2 years? ..... YES NO
   Physician's Name _____ Phone # (____) _____ - _____
   Address: _____
6. Are you sensitive or allergic to any medication or anesthetics? (please specify)..... YES NO
7. Indicate which of the following you have had or have at present. Circle "yes or no" to each item.

Heart Failure	YES	NO	Artificial Joints (hip,knee, etc.).....	YES	NO	Allergy to Latex	YES	NO
Heart Disease or Attack	YES	NO	Kidney Trouble.....	YES	NO	Allergy to Metal (Jewelry, etc.) ...	YES	NO
Angina Pectoris	YES	NO	Ulcers.....	YES	NO	Venereal Disease	YES	NO
Congenital Heart Disease ...	YES	NO	Diabetes.....	YES	NO	A.I.D.S.	YES	NO
Heart Murmur	YES	NO	Thyroid Problems.....	YES	NO	H.I.V. Positive	YES	NO
High Blood Pressure	YES	NO	Glaucoma.....	YES	NO	Cold Sores/Fever Blisters	YES	NO
Arteriosclerosis	YES	NO	Cancer.....	YES	NO	Blood Transfusion	YES	NO
Mitral Valve Prolapse	YES	NO	Emphysema.....	YES	NO	Hemophilia	YES	NO
Artificial Heart Valve	YES	NO	Chronic Cough.....	YES	NO	Anemia.....	YES	NO
Heart Pacemaker	YES	NO	Tuberculosis.....	YES	NO	Sickle Cell Disease	YES	NO
Heart Surgery	YES	NO	Asthma.....	YES	NO	Bruise Easily	YES	NO
Rheumatic Fever	YES	NO	Hay Fever.....	YES	NO	Liver Disease	YES	NO
Arthritis	YES	NO	Allergies or Hives.....	YES	NO	Yellow Jaundice.....	YES	NO
Rheumatism	YES	NO	Sinus Trouble.....	YES	NO	Epilepsy or Seizures	YES	NO
Cortisone Medicine	YES	NO	Radiation Therapy.....	YES	NO	Fainting or Dizzy Spells.....	YES	NO
Drug Addiction	YES	NO	Chemotherapy.....	YES	NO	Nervousness	YES	NO
Stroke.....	YES	NO	Hepatitis A (infectious).....	YES	NO	Tumors	YES	NO
Hepatitis B (serum).....	YES	NO	Developmentally Disabled	YES	NO			

8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? ..... YES NO
9. Do your ankles swell during the day? ..... YES NO
10. Do you use more than two pillows to sleep? ..... YES NO
11. Have you lost or gained more than 10 pounds in the past year? ..... YES NO
12. Do you ever wake up from sleep and feel short of breath? ..... YES NO
13. Are you on a special diet? (please specify)..... YES NO
14. Do you have or have you had any disease, condition, or problem not listed?..... YES NO
    If yes, please list:_____

FOR WOMEN ONLY:

Are you pregnant? ☐ Yes...what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____