Dental and Medical History

I certify that all of the preceding answers and information provided are True and correct to the best of my knowledge. I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I understand that providing incorrect information can be dangerous to my health. I have read and understand the above questions. I will not hold C. Y. Lee D.D.S Inc. and its affiliated general dentist, and auxiliary staff responsible for any errors or omissions that I have made in the completion of this form. If there're any changes later to this history record or medical/dental status I will inform C. Y. Lee D.D.S Inc.

Assignment and Release

I and/or my dependent(s) assign directly to C. Y. Lee D.D.S Inc. 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 C. Y. Lee D.D.S Inc. to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to the third party payers and/or health practitioners for the purpose of obtaining payment and determining Insurance benefit payable for services.

Content for services

I understand and consent to have any treatment done by the dentist after the procedure, the risks, the benefits, and the costs have you been fully explained. These treatments include but not limited to X-rays, cleanings, periodontal treatments, fillings, crowns, bridges, extractions, root canals, implants, and/or dentures. As a condition of your treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee to call me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to content.

_____ Date: _____ Relationship to Patient: _____

Signature of Patient, parents or guardian/responsible party

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

_____ Date: _____

Signature of Patient, parents or guardian/responsible party

Office Use Only: **Medical and Dental History Review Performed by**

Signature: _____ Date: _____

Patient Medical History

1. Primary Physician

   Name: _____

   Phone: _____ Date of last visit: _____

2. Do you smoke or use tobacco in any form: ☐ Yes ☐ No

3. Are you taking or have you taken diet drug such as Fen-Phen or Redux? ☐ Yes ☐ No

4. Do you have or have you had any of the following? (Please mark each line with Yes or No)

AIDS/HIV Positive	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Allergies: _____	☐ Yes	☐ No	Hepatitis Type ____	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Artificial joint/Implant	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Bruise easily	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Cancer: _____	☐ Yes	☐ No	Mental Disorders	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Chest Pain/Angina	☐ Yes	☐ No	Nervous Disorders	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Respiratory Problems	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No
Fainting	☐ Yes	☐ No	Stomach Problems	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No	Swollen Ankle	☐ Yes	☐ No
Head/Jaw Injuries	☐ Yes	☐ No	Thyroid Problem	☐ Yes	☐ No
			Tuberculosis	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Skin Rash	☐ Yes	☐ No			
Bleeding abnormally with extractions or surgery	☐ Yes	☐ No			

5. Do you have or have you had any disease condition, or Health problem not listed above or need further clarifications? ☐ Yes ☐ No

   If Yes, please explain: _____

C.Y. Lee D.D.S.

Patient Information

Patient Name: _____
Last First Middle Initial

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____

Address: _____

Phone: (Home): _____ (work): _____ (cell): _____

Email Address: _____

Family Status: ☐ Minor ☐ Single ☐ Married ☐ Other: _____

Emergency Contact: _____
Name Phone Number Relation to patient

Whom may we thank for referring you: _____

Employee/School name: _____ Occupation: _____

Insurance Information

Is insured the patient? ☐ Yes ☐ No If No, Name/SSN/DOB of insured: _____

Insurance Company: _____ Group #: _____ Policy #: _____

Do you have additional insurance? ☐ Yes ☐ No If Yes, 2nd insurance company: _____

Dental History

Name of Previous dentist: _____ Date of last visit: _____ Date of last cleaning: _____

Do you have or have you had any of the following: (Please check all that apply)

☐ Deep cleaning	☐ Sensitivity when biting	☐ Clicking or popping jaw	☐ Chew on one side of mouth
☐ Orthodontic treatment	☐ Tender or swollen gums	☐ Jaw pain or tiredness	☐ Difficult extractions in the past
☐ Bleeding gums	☐ Bad breath	☐ Pain around ear	☐ Difficulty in opening / closing jaw
☐ Sensitivity to cold liquid	☐ Grinding teeth	☐ Dry mouth	☐ Difficulty in chewing
☐ Sensitivity to hot liquid/food	☐ A mouth guard or bite plate	☐ Frequent headaches	☐ Food collections between teeth
☐ Sensitivity to sweets	☐ Oral/gum surgery	☐ Complications following dental treatment	

Medications

Are you taking any medication or undergoing any medical treatment? ☐ Yes ☐ No

List medications and the correlating diagnosis: _____

Allergies

Are you allergic to or have had any reaction to the following? ☐ Yes ☐ No

☐ Local anesthetics (i.e., novacaine)	☐ Sulfa drugs	☐ Sedative	☐ Lodine	☐ Any metals (nickel, mercury)
☐ Penicillin or other antibiotics	☐ Aspirin/Tylenol	☐ Latex rubber	☐ Other – Please describe: _____	

Women Only

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No