Better Living through Dentistry
John Kong, DDS

# PATIENT INFORMATION FORM

## Personal Information

Date: ____________________

❑ Dr ❑ Mr ❑ Mrs ❑ Ms ❑ Miss

Name: ____________________

Email: ____________________

Social Security #: ____________________

Street Address: ____________________

City: ____________________

State: ____________ Zip: ____________

Home phone: ____________________

Cell phone: ____________________

Work phone: ____________________

Place of Employment: ____________________

Date of Birth: ____________________

❑ Male ❑ Female ❑ Married ❑ Single ❑ Other

## Dental Insurance Information

Primary Insurance Provider: ____________________

Policy in the name of: ____________________

Policyholder's Date of Birth: ____________________

Contract #: ____________ Group #: ____________

Secondary Insurance Provider: ____________________

Policy in the name of: ____________________

Policyholder's Date of Birth: ____________________

Contract #: ____________ Group #: ____________

## Medical Insurance Information

Primary Insurance Provider: ____________________

Policy in the name of: ____________________

Policyholder's Date of Birth: ____________________

Contract #: ____________ Group #: ____________

## Dental History

Reason for visit: ____________________

Name of Referring Dentist: ____________ Date of last visit: ____________ Recent X-rays: ❑ Yes ❑ No

Have you ever had treatment for gum problems? ❑ Yes ❑ No ____________________

## Confidential Medical History

Physician's name: ____________ Telephone #: ____________ Date of last visit: ____________

Are you under a doctor's care now? ❑ Yes ❑ No ____________________

Have you been hospitalized in the last 5 years? ❑ Yes ❑ No ____________________

Do you bleed excessively when cut? ❑ Yes ❑ No Do you smoke? ❑ Yes ❑ No

Do you have allergies? ❑ Yes ❑ No If so, to what? ____________________

Do you need to premedicate prior to dental treatment? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Taking biphosphonates? ❑ Yes ❑ No If yes: ❑ Oral ❑ IV

Have you had or do you have any of the following? Please check all that apply:

❑ Heart Murmur/Mitral Valve Prolapse
❑ Rheumatic Fever
❑ Pacemaker
❑ Cancer
❑ Malignancy
❑ Radiation or Chemotherapy
❑ Digestive Disorders
❑ Metal Allergy
❑ Chemical/Alcohol Dependency
❑ High Blood Pressure
❑ Low Blood Pressure
❑ Thyroid Disorder
❑ Psychiatric Care/Depression
❑ Diabetes
❑ Artificial Joints or Valves
❑ Epilepsy
❑ Stroke
❑ Head and Neck Pain
❑ Glaucoma
❑ Latex Allergy
❑ HIV+
❑ Kidney Disease
❑ Venereal Disease
❑ Drug Addiction
❑ Scarlet Fever
❑ Tuberculosis
❑ Blood Disorder
❑ Anemia
❑ Liver Disease
❑ Hepatitis
❑ Asthma
❑ Hay Fever
❑ Sinus Problems
❑ TMJ

Please indicate any other serious illness not indicated above: ____________________

Please list medication(s): ____________________

## Informed Consent

I have read, understood and completed accurately the above information. Further, I give permission to the doctors to use anesthetics ("Novocain") as necessary to complete my dental treatment.

Signature: ____________ Relationship to Patient: ____________ Date: ____________