## Welcome To Our Office!

Patient Information						
Last name:	First name:	M:	Nickname:			
Address:	Cit	y:	State:	Zip:		
Home phone: ()	Work phone: ()	C	ell phone: ()			
If patient is a minor Parents Name		E-Mail				
Patient's date of birth://	Sex: M / F	Social Security Nu	mber:			-
Marital status: M D W S Occupation:		Employer:_				
Who referred you to our office, or ho	w did you hear about us	s?				_
Emergency contact:	Ве	st number for daytin	1e contact: ()			
Dental Insurance Information						
Primary Insurance Co:	Ph	one: ()	Group #:			
Employee:						
Employer:						
Secondary Insurance Co.:						
Employee:	Date of	birth://				
Employer:	Phone: (	)				
Are you currently undergoing treatme Physician's name and phone #: Do you have serious health problems Have you had a serious illness, operat Are you taking prescription (including If so, please list them here:	? Explain: tion or been hospitalize g birth control) or over t	d in the past 5 years he counter medicatio	? Explain		_ Y _ Y	N N ( N
Has a physician recommended that ye	ou take an antibiotic pri	or to any dental trea	tment? Explain:		Y	N
Have you had any joint replacements	? Evolain:				v	N
Do you have or have you had artificia					- ·	
Damaged valves in a transplanted hea	-	•	•	••	Y	N
Are you currently taking or have you (pamidronate), Bonefos (clodronate), (clodronate), Skelid (filudronate), Zor For osteoporosis, Paget's Disease, mu	taken any bisphosphon , Boniva (ibandronate), I neta (soledronic acid), a	ate medications such Didronel (etidronate nd/or are you being	as Actonel (resodro ), Fosamax (alendro treated or have trea	onate), Are nate), Osta atment pla	ac anne	
Are you sensitive or allergic to any of	the following (Y for Yes	& N for No)?				
Local anesthetics (lidocaine) Y N	Codeine or Narcoti		Metals	Y	Ν	
Pain medications Y N	Antibiotics	Y N	Latex (rubber)	Y	Ν	
(which:)	(Which:	)	Other (explain :		)	

Do you have or have you had any of the following conditions (circle Y for yes or N for no)
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AIDS or HIV infection	Y	Ν	Liver disease	Y	Ν			
Angina or chest pain	Y	Ν	Epilepsy, fainting, seizures	Y	Ν	Mental health disorders	Υ	Ν
Arthritis	Y	Ν	Heart defects	Y	Ν	Neurological disorder	Υ	Ν
Asthma	Y	Ν	Headaches (frequent)	Y	Ν	Pacemaker	Y	Ν
Autoimmune disease	Y	Ν	Heart attack (when :	_) Y	Ν	Persistent swollen neck gland	ds Y	Ν
Anemia	Y	Ν	Heart disease or surgery	Y	Ν	Heart palpitations	Y	Ν
High blood pressure	Y	Ν	Heart murmur	Y	Ν	Sexually transmitted disease	Y	Ν
Low blood pressure	Y	Ν	Heart valve issue	Y	Ν	Sinus problems (frequent)	Y	Ν
Blood thinners taken	Y	Ν	Hemophilia	Y	Ν	Stomach, intestinal problems	5 Y	Ν
Osteoporosis	Y	Ν	Hepatitis	Y	Ν	Stroke (when :	_) Y	Ν
Cancer chemotherapy, r	adiatior	า	Infection (recurrent)	Y	Ν	Systemic lupus erythematosu	ıs Y	Ν
Treatment	Y	Ν	Kidney problems	Y	N	Thyroid problems	Y	Ν
Chronic pain(where :	)Y	Ν	Leukemia	Y	Ν	Tuberculosis, blood w/cough	Y	Ν
Diabetes	Y	Ν	Lung Problems, emphysema	۱,		Blood disease	Y	Ν
Jaundice	Y	Ν	Bronchitis, difficulty breath	ing Y	Ν	Arteriosclerosis	Y	Ν

For women only – Are you pregnant? Y N If yes, how far along: \_\_\_\_\_\_

If you have a disease, condition or problem not listed above that we should know about, please explain here: \_\_\_\_\_

<u>Dental Information</u> Last dentist seen:	Date of last exam:	Date of last cleaning:		
Have you had any serious pro	blems with past dental treatment incl	uding anesthetics, medication or clotting?	Y	N
Explain:				

<u>Have you had any of the following (check all that apply)?</u>

$\circ$ Broken facial or jaw bones	$\circ$ Gum deep cleaning (date:)	$\circ$ Jaw joint (TMJ) problems
$\circ$ Facial nerve or mouth damage	$\circ$ Gum surgery (date:)	$\circ$ Orthodontic treatment

I agree to have work done on my self and my family. I agree to notify the office of any changes in my medical history or dental insurance. I will be sure to have my treatment or financial questions answered before starting treatment. To the best of my knowledge, the information I have provided to the office is correct. I authorize my insurance payment, if any, to be sent directly to Bin H. Park D.D.S. A photocopy of this is as if it were the original.

\_\_\_\_\_ Date \_\_\_\_\_

Patient's signature (parent or guardian if a minor)	Date
ratione of Subratary	Butt

Doctor's signature		

## Staff use only-For yearly health history updates

Changes or comments	Initials	Date	Changes or comments	Initials