PATIENT INFORMATION

(This information is necessary for our files and will be considered **CONFIDENTIAL**) Date_____

Patient's Name_____ Age___ Patient's Birthday_____ □ Male □ Female
LAST FIRST INITIAL
If patient is a minor, give name of parent or legal guardian_____ Relationship_____
Patient is □ Married □ Single □ Divorced □ Separated □ Widowed □ Minor Driver's License No._____
Residence Address_____
STREET CITY ZIP
Social Security No._____ Residence Phone (_____)_____ Cell Phone (_____)_____
Employed by_____ Occupation_____
Business Address_____ Business Phone(_____)_____
STREET CITY ZIP
Spouse Name_____ Driver's License No._____ Social Security No._____
Employed by_____ Occupation_____
Business Address_____ Business Phone (____)_____
Emergency Contact_____ Relationship_____
Complete Address_____ Residence Phone (____)_____
STREET CITY ZIP □ I have no physician
Name of Physician_____ (____)_____
ADDRESS TELEPHONE
Former Dentist_____ (____)_____
ADDRESS TELEPHONE
Why are you changing dentists?_____
Is this visit for Emergency Dental Care? □ Yes □ No If yes, explain:_____

FINANCIAL INFORMATION

Person responsible for this account_____ Relationship_____
Address_____ (____)_____
STREET CITY TELEPHONE
Name of insurance company (primary insurance)_____
_____
INSURED PERSON'S NAME BIRTHDAY RELATIONSHIP SOC. SEC. NO.
_____
NAME OF GROUP DENTAL PLAN GROUP NO.
Name of insurance company (secondary insurance)_____
_____
INSURED PERSON'S NAME BIRTHDAY RELATIONSHIP SOC. SEC. NO.
_____
NAME OF GROUP DENTAL PLAN GROUP NO.

TERMS AND CONDITIONS

I hereby authorize Dr. Hsu and his staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis. I give permission for this office to give reminder calls to my home and/or office in regards to appointment times and dental procedures. I understand that I will be responsible for fee, if I do not notify the office a minimum of 24 hours before canceling my scheduled appointment.

I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to myself. I understand that my dental insurance carrier may pay less than the actual fee for services. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I understand that payment is due at the time of service unless other arrangements have been made. In the event that payments are not received by agreed upon dates, I understand that a late charge may be added to my account not to exceed 1.5% (18% APR). I understand that the fee estimate for dental treatment can only be extended for a period of six months from the date of the patient's examination.

To the extent permitted under applicable law, I authorize release of any information, including diagnosis and the records of any treatment or examinations rendered to my child or myself during the period of such dental care to third party payers and other health practitioners. I understand that this office makes every effort to maintain patient privacy. The staff is trained using the HIPPA guidelines on the most effective way of maintaining the patient's most private and personal information. I acknowledge that I have read the Notice of Privacy Practices and have been offered a copy of the Notice. Should I wish to obtain another copy or have any questions, I will contact the Front Desk/Privacy Officers. I acknowledge that I have read and have access (from the front desk) to a copy of the Dental Materials Fact Sheet.

_____ _____
PATIENT/GUARDIAN SIGNATURE DATE

HEALTH QUESTIONNAIRE

MEDICAL HISTORY

1. Date of your last physical examination?_____
2. Are you now under the care of a physician?…….. Yes No
   If so, what is the condition being treated?_____
3. Have you ever had any serious illness or operation?…….. Yes No
   If so, what illness or operation?_____
4. Have you ever been hospitalized?…….. Yes No
   If so, what was the problem?_____
5. Are you taking any □ medications, □ drugs or □ herbs?…..…Yes No
   If so what?_____
   What dosage?_____
6. Have you ever been premedicated with antibiotics for your dental treatment?……..Yes No
7. Are you sensitive or allergic to any drugs or materials?…….Yes No
   If yes, what drugs?_____

8. Do you have or have you had any of the following: (Please circle '**Y**' for Yes or '**N**' for No-answer all conditions):

Y N	Anemia	**Y N**	Sinus Trouble	**Y N**	Angina Pectoris	**Y N**	Mitral Valve Prolapse
Y N	Herpes	**Y N**	Heart Murmur	**Y N**	Mental Disorder	**Y N**	High Blood Pressure
Y N	Stroke	**Y N**	Liver Disease	**Y N**	Fainting Spells	**Y N**	HIV Related Complex
Y N	Ulcers	**Y N**	Blood Disease	**Y N**	Blood Transfusion	**Y N**	Respiratory Disease
Y N	Diabetes	**Y N**	Congenital Heart Defect	**Y N**	Joint Replacement	**Y N**	Epilepsy or Seizures
Y N	Tuberculosis	**Y N**	Heart Attack	**Y N**	Nervous Disorders	**Y N**	Psychiatric Treatment
Y N	Asthma	**Y N**	Heart Failure	**Y N**	Tumors or Growths	**Y N**	Hepatitis or Jaundice
Y N	Cancer	**Y N**	Kidney Disease	**Y N**	Pain in Jaw Joints	**Y N**	Difficulty Swallowing
Y N	Hay Fever	**Y N**	Chicken Pox	**Y N**	Hemophilia	**Y N**	Radiation Treatment
Y N	Glaucoma	**Y N**	Chemotherapy	**Y N**	Sickle Cell Disease	**Y N**	Venereal Disease
Y N	Cold Sores	**Y N**	Bruise Easily	**Y N**	Cortisone Medicine	**Y N**	AIDS
Y N	Artificial Prosthesis	**Y N**	Stomach Ulcers	**Y N**	Thyroid Disease	**Y N**	TMJ
Y N	Emphysema	**Y N**	Cerebral Palsy	**Y N**	Allergies to Meta	**Y N**	Excessive Bleeding

9. Do you have any disease, condition or problem not listed that you think we should know about?……Yes No
   If so, what?_____
10. Do you smoke? If yes, how much_____ □ Cigarettes □ Cigars □ Packs per day…….. Yes No
11. Do you wear a cardiac pacemaker, or have you had heart surgery?……. Yes No
12. (Women) Are you pregnant? If so, how many months?_____ Yes No
13. (Women) Do you take any birth control medication or hormones?……. Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic?…….. Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic?…… Yes No
3. Have you had any serious trouble associated with any previous dental treatment?…….. Yes No
   If so, explain?_____
4. Would you desire to be pre-sedated?……. Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health or if my medications change, I will, without fail, inform the doctor at my next appointment.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the Terms and Conditions printed on the Patient Information sheet:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**