



TONG  
DENTAL  
CARE

# WELCOME TO OUR PRACTICE!

## PATIENT INFORMATION - ADULT

TODAY'S DATE \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **F M**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed

Spouse's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## CONTACT INFORMATION

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_ Best time to reach you: Morning Afternoon Evening

In case of an emergency, contact (please specify): \_\_\_\_\_

Home Number: \_\_\_\_\_ Work Number: \_\_\_\_\_ ext: \_\_\_\_\_ Relationship: \_\_\_\_\_

Can we email and/or send a text message to your cell to confirm your appointment?

Yes, both are ok Email only Text only No, I'd prefer a phone call

## INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Group (Policy) Number: \_\_\_\_\_

Ins. Company Address: \_\_\_\_\_ Ins. Company Number: \_\_\_\_\_

Policy Owner's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policy Owner's DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

## Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Tong 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

\_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party Signature

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MEDICAL ALERTS**

List any medications you are taking and the correlating diagnosis: _____ _____ Pharmacy Name: _____ Phone #: _____	<p style="text-align: center;"><b>Allergies</b></p> <input type="checkbox"/> Aspirin <input type="checkbox"/> Barbiturates (Sleeping Pills) Sulfa <input type="checkbox"/> Local Anesthetics <input type="checkbox"/> Penicillin (Amoxicillin) <input type="checkbox"/> Codeine <input type="checkbox"/> Iodine <input type="checkbox"/> Latex <input type="checkbox"/> Other: _____
---	---

**DENTAL HISTORY**

Reason for today's visit: _____ _____ Former Dentist: _____ Phone #: _____ Date of dental last visit: _____ Date of last dental x-ray: _____ How often do you brush? _____ How often do you floss? _____	Please circle "Yes" or "No" to indicate if you have any of the following: Bad breath <b>Yes No</b> Bleeding gums <b>Yes No</b> Burning sensation on tongue <b>Yes No</b> Chew on one side of mouth <b>Yes No</b> Cigarette/pipe/cigar smoking <b>Yes No</b> Clicking/popping jaw <b>Yes No</b> Dry Mouth <b>Yes No</b> Food collection bet. teeth <b>Yes No</b> Grinding teeth <b>Yes No</b> Gums swollen/tender <b>Yes No</b>	Jaw pain/tiredness <b>Yes No</b> Loose/broken tooth <b>Yes No</b> Fillings <b>Yes No</b> Mouth breathing <b>Yes No</b> Mouth pain when brushing <b>Yes No</b> Pain around ear <b>Yes No</b> Periodontal treatment <b>Yes No</b> Sensitivity of cold <b>Yes No</b> Sensitivity to heat <b>Yes No</b> Sensitivity when biting <b>Yes No</b> Sores/growths in your mouth <b>Yes No</b>
---	--	---

**HEALTH HISTORY**

Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please circle "Yes" or "No" to indicate if you have any of the following:

AIDS/HIV	<b>Yes No</b>	Epilepsy	<b>Yes No</b>	Respiratory Disease	<b>Yes No</b>
Anemia	<b>Yes No</b>	Fainting or Dizziness	<b>Yes No</b>	Rheumatic Fever	<b>Yes No</b>
Arthritis/Rheumatism	<b>Yes No</b>	Glaucoma	<b>Yes No</b>	Scarlet Fever	<b>Yes No</b>
Artificial Heart Valves	<b>Yes No</b>	Headaches	<b>Yes No</b>	Shortness of Breath	<b>Yes No</b>
Artificial Joints	<b>Yes No</b>	Heart Murmur	<b>Yes No</b>	Sinus Trouble	<b>Yes No</b>
Asthma	<b>Yes No</b>	Heart Problems	<b>Yes No</b>	Skin Rash	<b>Yes No</b>
Back Problems	<b>Yes No</b>	Hepatitis Type	<b>Yes No</b>	Special Diet	<b>Yes No</b>
Bleeding Abnormally with extractions or surgery	<b>Yes No</b>	Herpes	<b>Yes No</b>	Stroke	<b>Yes No</b>
Blood Disease	<b>Yes No</b>	High Blood Pressure	<b>Yes No</b>	Swollen Feet or Ankles	<b>Yes No</b>
Cancer	<b>Yes No</b>	Jaundice	<b>Yes No</b>	Swollen Neck or Glands	<b>Yes No</b>
Chemical Dependency	<b>Yes No</b>	Jaw Pain	<b>Yes No</b>	Thyroid Problems	<b>Yes No</b>
Chemotherapy	<b>Yes No</b>	Kidney Disease	<b>Yes No</b>	Tonsillitis	<b>Yes No</b>
Circularity Problems	<b>Yes No</b>	Liver Disease	<b>Yes No</b>	Tuberculosis	<b>Yes No</b>
Congenital Heart Lesions	<b>Yes No</b>	Low Blood Pressure	<b>Yes No</b>	Tumor/Growth on Head/Neck	<b>Yes No</b>
Cortisone Treatments	<b>Yes No</b>	Mitral Valve Prolapse	<b>Yes No</b>	Ulcer	<b>Yes No</b>
Cough, Persistent or Bloody	<b>Yes No</b>	Nervous Problems	<b>Yes No</b>	Venereal Disease	<b>Yes No</b>
Diabetes	<b>Yes No</b>	Pacemaker	<b>Yes No</b>	Weight Loss, Unexplained	<b>Yes No</b>
Emphysema	<b>Yes No</b>	Psychiatric Care	<b>Yes No</b>		
		Radiation Treatment	<b>Yes No</b>		

**WOMEN:** Are you pregnant? **Yes No** Due Date: \_\_\_\_\_ Are you nursing? **Yes No** Taking birth control? **Yes No**

**Authorization**

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and is my responsibility to inform this office of any changes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_