TONG DENTAL CARE

WELCOME TO OUR PRACTICE!

PATIENT INFORMATION - ADULT **TODAY'S DATE** _____

Patient's Name: _____ SSN: _____
Last First Middle

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 #: _____

Allergies

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills) Sulfa
- ☐ Local Anesthetics
- ☐ Penicillin (Amoxicillin)
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ 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	**Yes**	**No**
Bleeding gums	**Yes**	**No**
Burning sensation on tongue	**Yes**	**No**
Chew on one side of mouth	**Yes**	**No**
Cigarette/pipe/cigar smoking	**Yes**	**No**
Clicking/popping jaw	**Yes**	**No**
Dry Mouth	**Yes**	**No**
Food collection bet. teeth	**Yes**	**No**
Grinding teeth	**Yes**	**No**
Gums swollen/tender	**Yes**	**No**

Jaw pain/tiredness	**Yes**	**No**
Loose/broken tooth	**Yes**	**No**
Fillings	**Yes**	**No**
Mouth breathing	**Yes**	**No**
Mouth pain when brushing	**Yes**	**No**
Pain around ear	**Yes**	**No**
Periodontal treatment	**Yes**	**No**
Sensitivity of cold	**Yes**	**No**
Sensitivity to heat	**Yes**	**No**
Sensitivity when biting	**Yes**	**No**
Sores/growths in your mouth	**Yes**	**No**

HEALTH HISTORY

Physician's Name: _____ Phone #: _____

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

AIDS/HIV	**Yes**	**No**
Anemia	**Yes**	**No**
Arthritis/Rheumatism	**Yes**	**No**
Artificial Heart Valves	**Yes**	**No**
Artificial Joints	**Yes**	**No**
Asthma	**Yes**	**No**
Back Problems	**Yes**	**No**
Bleeding Abnormally with extractions or surgery	**Yes**	**No**
Blood Disease	**Yes**	**No**
Cancer	**Yes**	**No**
Chemical Dependency	**Yes**	**No**
Chemotherapy	**Yes**	**No**
Circularity Problems	**Yes**	**No**
Congenital Heart Lesions	**Yes**	**No**
Cortisone Treatments	**Yes**	**No**
Cough, Persistent or Bloody	**Yes**	**No**
Diabetes	**Yes**	**No**
Emphysema	**Yes**	**No**

Epilepsy	**Yes**	**No**
Fainting or Dizziness	**Yes**	**No**
Glaucoma	**Yes**	**No**
Headaches	**Yes**	**No**
Heart Murmur	**Yes**	**No**
Heart Problems	**Yes**	**No**
Hepatitis Type	**Yes**	**No**
Herpes	**Yes**	**No**
High Blood Pressure	**Yes**	**No**
Jaundice	**Yes**	**No**
Jaw Pain	**Yes**	**No**
Kidney Disease	**Yes**	**No**
Liver Disease	**Yes**	**No**
Low Blood Pressure	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**
Nervous Problems	**Yes**	**No**
Pacemaker	**Yes**	**No**
Psychiatric Care	**Yes**	**No**
Radiation Treatment	**Yes**	**No**

Respiratory Disease	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**
Scarlet Fever	**Yes**	**No**
Shortness of Breath	**Yes**	**No**
Sinus Trouble	**Yes**	**No**
Skin Rash	**Yes**	**No**
Special Diet	**Yes**	**No**
Stroke	**Yes**	**No**
Swollen Feet or Ankles	**Yes**	**No**
Swollen Neck or Glands	**Yes**	**No**
Thyroid Problems	**Yes**	**No**
Tonsillitis	**Yes**	**No**
Tuberculosis	**Yes**	**No**
Tumor/Growth on Head/Neck	**Yes**	**No**
Ulcer	**Yes**	**No**
Venereal Disease	**Yes**	**No**
Weight Loss, Unexplained	**Yes**	**No**

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: _____