# Jade T Ong, DDS, Inc.

Dentistry With A Gentle Touch

## Patient Information / Medical & Dental History / Insurance Information

### 1. ABOUT YOU

**Name:** ❐Mr. ❐Mrs. ❐Ms. ❐Dr. Date:

| First: | MI: | Last: |
|---|---|---|
| | | |

**Address:**

| Street | | |
|---|---|---|
| City: | State: | Zip: |

**Email:**

| |
|---|
| |

**Phone:**

| Home: | Work: | Ext. |
|---|---|---|
| Fax: | Pager: | Cell |

**Employer:**

| Company Name | | |
|---|---|---|
| Street | | |
| City: | State: | Zip: |

**Others:**

| Sex: ❐Male ❐Female | Marital Status: ❐Single ❐Married ❐Divorced ❐Widowed ❐Separated | |
|---|---|---|
| Birthdate: | Social Security Number: | Other ID: |
| Driver's License: | Preferred Name: | |
| Whom may we thank for referring you? | | |
| Other family members seen by us: | | |
| Previous / Present Dentist: | | |
| Dentist Phone #: | Last Visit Date: | |

### 2. SPOUSE / RELATIVE INFORMATION

| First: | MI: | Last: |
|---|---|---|
| Street | | |
| City: | State: | Zip: |

**Neighbor or Relative not living with you in case of emergency:**

| Name: | | |
|---|---|---|
| Street | | |
| City: | State: | Zip: |
| Phone: | Relation: | |

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### MEDICAL HISTORY

Do you have a personal physician? ☐Yes ☐No

Physician's Name: ____________________________________________

Phone #: ______________________ Last Visit: ____________________

**Your current physical health is:** ☐**Good** ☐**Fair** ☐**Poor**

Are you currently under the care of a physician? ☐Yes ☐No

Please explain: _______________________________________________

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Have you had any metal rods, pins or implants? ☐Yes ☐No

Are you taking any prescription / over-the-counter drugs? ☐Yes ☐No

Please list each one: ___________________________________________

**Have you ever had any of the following diseases or medical problems:**

| | | | | | |
|---|---|---|---|---|---|
| ☐Y | ☐N | Abnormal Bleeding | ☐Y | ☐N | Herpes / Fever Blisters |
| ☐Y | ☐N | Alcohol / Drug Abuse | ☐Y | ☐N | High/Low Blood Pressure |
| ☐Y | ☐N | Anemia | ☐Y | ☐N | HIV / AIDS |
| ☐Y | ☐N | Arthritis | ☐Y | ☐N | Hospitalized for Any Reason |
| ☐Y | ☐N | Artificial Body Parts | ☐Y | ☐N | Kidney Problems |
| ☐Y | ☐N | Asthma | ☐Y | ☐N | Liver Disease |
| ☐Y | ☐N | Blood Transfusion | ☐Y | ☐N | Low Blood Pressure |
| ☐Y | ☐N | Bruise Easily | ☐Y | ☐N | Mitral Valve Prolapse |
| ☐Y | ☐N | Cancer/Chemotherapy | ☐Y | ☐N | Nervous Disorders |
| ☐Y | ☐N | Chest Pain | ☐Y | ☐N | Pacemaker |
| ☐Y | ☐N | Colitis | ☐Y | ☐N | Psychiatric Imbalance |
| ☐Y | ☐N | Congenital Heart Defect | ☐Y | ☐N | Radiation Treatment |
| ☐Y | ☐N | Diabetes | ☐Y | ☐N | Respiratory Disease |
| ☐Y | ☐N | Difficulty Breathing | ☐Y | ☐N | Rheumatic / Scarlet Fever |
| ☐Y | ☐N | Emphysema | ☐Y | ☐N | Seizures |
| ☐Y | ☐N | Epilepsy | ☐Y | ☐N | Shingles |
| ☐Y | ☐N | Fainting Spells | ☐Y | ☐N | Sickle Cell Disease / Traits |
| ☐Y | ☐N | Frequent Headaches | ☐Y | ☐N | Sinus Problems |
| ☐Y | ☐N | Glaucoma | ☐Y | ☐N | Stroke |
| ☐Y | ☐N | Hay Fever | ☐Y | ☐N | Thyroid Problems |
| ☐Y | ☐N | Head / Neck Injuries | ☐Y | ☐N | Tuberculosis (TB) |
| ☐Y | ☐N | Heart Attack/Surgery | ☐Y | ☐N | Tumors / Growths |
| ☐Y | ☐N | Heart Murmur | ☐Y | ☐N | Ulcers |

| | | | | | |
|---|---|---|---|---|---|
| ☐Y | ☐N | Hemophilia | ☐Y | ☐N | Venereal Disease |
| ☐Y | ☐N | Hepatitis | | | |

**For Women:** Are you taking birth control pills? ☐Yes ☐No

Anything you would like to discuss with the dentist in private? ☐Yes ☐No

Please list any serious medical conditions(s) that you have ever had:

_______________________________________________________________

**Are you allergic to any of the following?**

| | | | | | |
|---|---|---|---|---|---|
| ☐Y | ☐N | Aspirin | ☐Y | ☐N | Codeine |
| ☐Y | ☐N | Dental Anesthetics | ☐Y | ☐N | Erythromycin |
| ☐Y | ☐N | Jewelry/Metals | ☐Y | ☐N | Latex |
| ☐Y | ☐N | Penicillin | ☐Y | ☐N | Tetracycline |
| ☐Y | ☐N | Other | ☐Y | ☐N | |

Please list any other drugs that you are allergic to:

_______________________________________________________________

_______________________________________________________________

### DENTAL HISTORY

**Why have you come to the dentist today?**

_______________________________________________________________

_______________________________________________________________

Have you ever taken Phen-Phen?

Also known as Redux & Pondimin ☐Yes ☐No

If so, when ______________________________________________

Do you need to be premedicated before dental treatment? ☐Yes ☐No

Are you currently in pain? ☐Yes ☐No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMDJ)? ☐Yes ☐No

Your current dental health is ☐Good ☐Fair ☐Poor

Do you like your smile? ☐Y ☐N Do your gums ever bleed? ☐Y ☐N

How many times a week do you floss? ____ a day do you brush? ___________

Type of bristles? ☐Hard ☐Medium ☐Soft

How long do you use a toothbrush before replacing it? ____________________

Are your teeth sensitive to heat, cold, or anything else? ___________________

_______________________________________________________________

Have you lost any teeth? ☐Yes ☐No

If yes, why? ____________________________________________________

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

_____________________________________________

Signature / Date

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### 3. INSURANCE

**Primary Insurance:** Dental Coverage? ❐Yes ❐No Medical Coverage? ❐Yes ❐No

| | | |
|---|---|---|
| Name: | | |
| Street | | |
| City: | State: | Zip: |
| Phone: | Group# (Plan, Local or Policy#): | |
| Insured's Name: | Relation: | |
| Insured's Birthdate: | Insured's SS#: | |
| Insured's Employer: | Insured's Employer Address: | |

**Secondary Insurance:** Dental Coverage? ❐Yes ❐No Medical Coverage? ❐Yes ❐No

| | | |
|---|---|---|
| Name: | | |
| Street | | |
| City: | State: | Zip: |
| Phone: | Group# (Plan, Local or Policy#): | |
| Insured's Name: | Relation: | |
| Insured's Birthdate: | Insured's SS#: | |
| Insured's Employer: | Insured's Employer Address: | |

**Payment is due in full at the time of treatment**
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

________________________________________

Signature / Date