Louis K. Cheung DDS

Family | Cosmetic | Implant Dentistry

The benefits of a happy, healthy smile are immeasurable. Out goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 PATIENT INFORMATION

Date ______________________

Name ______________________

E-mail Address ______________________

I prefer to be called ____________ ☐ Male ☐ Female

Birthday ________ Age ______ SS # ____________

Home Address ______________________

____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm # ____________ Pager / Cell # ____________

Wk # ____________ Ext. ______ DL # ____________

Employer ______________________

Employer Address ______________________

How long there? ________ Occupation ____________

Where & when are the best times to reach you? ____________

Whom may we thank for referring you? ____________

Other family member seen by us ____________

Present / Previous Dentist ____________

Last visit date ____________

2 SPOUSE INFORMATION

Name ______________________

Employer ______________________

Email Address ______________________

Wk # ____________ Ext. ______ SS # ____________

Birthday ____________ DL# ____________

Person responsible for account ____________

Wk # ____________ Ext. ______ Home # ____________

Email Address ______________________

Billing Address ______________________

Relation ____________ SS # ____________

Employer ____________ DL # ____________

3 INSURANCE COVERAGE

PRIMARY

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name ______________________

Address ______________________

Phone ______________________

Group #, Plan, Local or Policy # ____________

Insured's Name ____________ Relation ____________

Insured's Birthdate ____________ Insured's ID # ____________

Insured's Employer ______________________

SECONDARY

Dental Coverage ☐ Yes ☐ No

Insurance Co. Name ______________________

Address ______________________

Phone ______________________

Group #, Plan, Local or Policy # ____________

Insured's Name ____________ Relation ____________

Insured's Birthdate ____________ Insured's ID # ____________

Insured's Employer ______________________

In the event of an emergency, is there someone who lives near you that we should contact?

Name ____________ Relation ____________

Physician's Name ____________ Hm# ____________

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name ______________________

Phone # ____________ Date of last visit? ____________

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

Please explain ______________________

4 MEDICAL HISTORY

Your current physical health is? ☐ Good ☐ Fair ☐ Poor

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

Please list each one ______________________________

____

Have you ever taken Fosamoa, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week # ______________

Are you nursing? ☐ Yes ☐ No

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

Y	N	Abnormal Bleeding	Y	N	Hepatitis
Y	N	Alcohol / Drug Abuse	Y	N	Herpes / Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV* / AIDS
Y	N	Artificial Bones / Joints / Valves	Y	N	Hospitalized for any Reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Treatment
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic / Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sickle Cell Disease / Traits
Y	N	Glaucoma	Y	N	Sinus Problems
Y	N	Hay Fever	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid Problems
Y	N	Heart Murmur	Y	N	Tuberculosis (TB)
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia	Y	N	Venereal Disease

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

____

____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Crythromycin	Y	N	Metals
Y	N	Codeine	Y	N	Jewelry	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Latex	Y	N	Tetracycline

Please list any other drugs / materials that you are allergic to ______________

____

5 DENTAL HISTORY

Why have you come to the dentist today? ______________________________

____

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ 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 join (TJM / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No

How many times a week do you floss? __________ a day do you brush? __________

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

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

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 help in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature Date

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 service rendered and also responsible for paying any copayment and deductible that my insurance does not cover.

____

Signature Date

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials ______________ Date ______________

Doctor's Comments ______________________________

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MEDICAL HISTORY UPDATE

1. Date ______________ Comments ______________________________ Signature ______________
2. Date ______________ Comments ______________________________ Signature ______________
3. Date ______________ Comments ______________________________ Signature ______________