Welcome

THANK YOU FOR SELECTING OUR DENTAL HEALTHCARE TEAM. DR. JONG WILL STRIVE TO PROVIDE YOU WITH THE BEST POSSIBLE DENTAL CARE. TO HELP US MEET ALL YOUR DENTAL HEALTHCARE NEEDS, PLEASE FILL OUT THIS FORM COMPLETELY. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE, PLEASE ASK US, WE WILL BE HAPPY TO HELP YOU.

Please print:

Patient Information (CONFIDENTIAL)

Name_____ Cell Phone_____

Address_____City_____State_____Zip Code_____

Date of Birth_____ Sex: ❑M ❑F Soc. Sec. No_____

Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Patient's Employer/School_____Work Phone_____

Home Phone_____ Email _____ Emergency Contact _____

Whom may we thank for referring you? _____

Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account_____

Relationship to Patient _____Home Phone_____

Address_____

Birthdate _____ Soc. Sec. No._____ Cell _____

Employer_____Work phone_____

Occupation_____

Is this person currently a patient in our office? ❑Yes ❑No

Dental Insurance Information:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Do you have additional dental insurance? ❑Yes ❑No If yes complete the following:

Name of Insured _____ Relationship to Patient_____

Subscriber's Birthdate_____Soc. Sec. No._____

Name of Employer _____Work Phone_____

Name of Dental Insurance Co. _____Group No._____

Ins. Co. Address_____City_____State_____Zip code_____

Other side

Medical History:

		Yes	No
1)	Are you under medical treatment now?	❑	❑
2)	Have you ever been hospitalized for any surgical operations or serious illness?	❑	❑
3)	Are you taking any medication(s) **including non-prescription** medications?	❑	❑
	If yes, please list **all** medications you are currently taking: _____ _____ _____		
4)	Do you use tobacco/vaping?	❑	❑
5)	Do you use alcohol or other drugs?	❑	❑
6)	Do you take an **aspirin daily**? ____mg	❑	❑
7)	Are you allergic to any of the following:		
	Local anesthetics (ex. Novocain)	❑	❑
	Penicillin or other antibiotics	❑	❑
	Sulfa drugs	❑	❑
	Barbiturates	❑	❑
	Sedatives	❑	❑
	Iodine	❑	❑
	Aspirin	❑	❑
	Other _____	❑	❑
8)	Women only		
	Are you pregnant or think you may be pregnant?	❑	❑
	Are you nursing?	❑	❑
	Are you taking birth control?	❑	❑

Do you suffer from any of the following?

	Yes	No
High Blood Pressure	❑	❑
Heart attack	❑	❑
Low blood pressure	❑	❑
Heart disease	❑	❑
Cardiac pacemaker	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Fainting	❑	❑
Asthma	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Diseases	❑	❑
HIV/AIDS	❑	❑
Radiation Therapy	❑	❑
Anemia	❑	❑
Emphysema/COPD	❑	❑
Cancer	❑	❑
Liver Disease /Hepatitis	❑	❑
Parkinsons/Alzheimer's	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Tuberculosis	❑	❑

Please list any others:

_____

_____

Dental History:

1) Are your teeth sensitive to hot, cold, sweet or sour liquid/food?
2) Do you feel pain in any of your teeth?
3) Have you ever had difficult extractions in the past?
4) Have you ever had prolonged bleeding following an extraction?
5) Date of last x-ray series is _____
6) Are you interested in teeth whitening?_____Invisalign?_____

Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. My method of payment will be _____. I certify that I am covered by _____ Insurance Company and I assign directly to this dental office all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing my signature, I have read and understand all of the above.

Signature:_____Date:_____