Patient and Financial Information

Patient Name Street Address City/State/ZIP

Patient E-Mail Please check your preferred method of contact. DOB

Email Cell Work Home

Home Phone Cell Phone Work Phone Employer Married/Domestic partner

Single

Insurance-Primary

Subscriber Name Relationship to Patient SSN DOB Subscriber SSN/ID

Subscriber Employer Insurance Company Name Insurance Company Address

Insurance Company Phone Number Group Number Policy Number

Insurance-Secondary

Subscriber Name Relationship to Patient SSN DOB Subscriber SSN/ID

Subscriber Employer Insurance Company Name Insurance Company Address

Insurance Company Phone Number Group Number Policy Number

In Case of Emergency, Whom May We Contact?

Name Relationship Phone

MEDICAL HISTORY

Physician’s Name Physician’s Phone Date of Last Visit

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

Have you been hospitalized or had a serious illness within the past 5 years? Yes No

If yes, please explain

Do you use tobacco in any form? Yes No If yes, please list type/frequency

Do you have any artificial joints? Yes No If yes, list type and surgery date

Are you taking any medication/drugs/supplements? If yes, please list each one.

Do you have any allergies? Yes No If yes, please list

Are you currently taking or have taken Fosamax or other osteoporosis medication? Yes No

Check all conditions that apply to you and list ones that are not mentioned.

Abnormal Bleeding Diabetes Heart Murmur Pace Maker

Alcohol Abuse Difficulty Breathing Heart Surgery Psychiatric Care

Allergies Drug Abuse Hemophilia Radiation Therapy

Anemia Emphysema Hepatitis A Rheumatic Fever

Angina Pectoris Epilepsy Hepatitis B Seizures

Arthritis Facial Surgery Hepatitis C STD

Artificial Heart Valve Fainting Spells High Blood Pressure Shingles

Asthma Fever Blisters Joint Replacement Sickle Cell Disease

Blood Transfusion Frequent Headaches Kidney Problems Sinus Problems

Cancer Glaucoma Liver Disease Stroke

Chemotherapy HIV+ AIDS Low Blood Pressure Thyroid Problems

Congenital Heart Defect Heart Attack Mitral Valve Prolapse Tuberculosis

Ulcers

If female, are you taking birth control pills nursing pregnant?

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Janice J. Wang, DDS 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 insurances. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I understand that the information 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.

Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_