DENTAL HISTORY OF PATIENT

Patient's Name: _____ Nickname: _____ Date of Birth: _____
Name of previous dentist: _____ City: _____ Phone: _____
Has any other member of your family been a patient of this office or our other office before? Yes: _____ No: _____
If so, please list their name(s): _____
Does the patient present with any dental problems &/or pain as far as you can tell or see? Please explain: _____

_____

Oral hygiene practices: Brushes _____ times a day. Flosses _____ times a day. Brushing is/is not (circle one) supervised by an adult.
History of trauma or injury to teeth (please describe): _____

I authorize routine dental diagnosis procedures for my child. I also agree to the use of anesthetics considered necessary and advisable by the dentist for the comfort and well-being of my child. I acknowledge that all the information I provide is accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL HISTORY OF PATIENT

For each question below, please circle yes or no. Your answers are for our records only and will remain confidential.

1. Is your child in good health? ……..... Yes No
2. Have there been any changes your child's health in the past year? ……. Yes No
3. Is your child currently under the care of a physician for non-routine visits? …… Yes No
   If so, what condition is being treated? _____
   Your child's last physical exam with the pediatrician was in: _____
   Name and address of your child's physician: _____
4. Has your child had any serious illness or operation in the past 5 years? …….. Yes No
   Please explain if yes: _____
5. Has your child been hospitalized in the past 5 years? ……... Yes No
   If so, what for: _____
6. Does the child have any of the following conditions or problems?
   a. Congenital birth defect; Explain: ……..…….. Yes No
   b. Rheumatic fever or rheumatic heart disease …… Yes No
   c. Congenital heart lesions/disease …….. Yes No
   d. Cardiovascular disease (heart trouble/attack, coronary insufficiency, coronary occlusion, high/low blood pressure) Yes No
   e. Heart murmur ……... Yes No
   f. Seasonal allergies ……..... Yes No
   g. Sinus troubles ……... Yes No
   h. Asthma ……. Yes No
   i. Hives or skin rashes, eczema, psoriasis …… Yes No
   j. Fainting spells or seizures ……. Yes No
   k. Diabetes …… Yes No
   l. Hepatitis, jaundice, or liver disease ……..... Yes No
   m. Arthritis …… Yes No
   n. Inflammatory rheumatism (painful swollen joints) …….. Yes No
   o. Stomach ulcers ……..... Yes No
   p. Tuberculosis …….. Yes No
   q. Persistent cough or coughing up blood ……..... Yes No
   r. Kidney trouble …….. Yes No
   s. Venereal disease ……..... Yes No
   t. Auto immune disease; Explain: ……. Yes No
   u. Recurrent/frequent headaches ……..... Yes No
   v. Blood disorder such as anemia, neutropenia, etc. ……. Yes No
   w. Autism or other pervasive developmental disorder ……..... Yes No
   x. Speech delay ……..... Yes No

y. ADHD ……..... Yes No
z. Other; Explain: ……...……. Yes No

7. Has your child had abnormal bleeding associated with previous extractions, surgeries, &/or trauma ..…….. Yes No
   a. Does your child bruise easily? ..……..... Yes No
   b. Has your child ever needed a blood transfusion? ……..…….. Yes No
      i. If so, please explain the circumstances: _____
8. Is your child currently taking any medications or supplements? ……..……. Yes No
   a. If yes, what: _____
9. Are any of the following medicines routinely ***used*** by your child?
   a. Antibiotics ……. Yes No
   b. Sulfa drugs …….. Yes No
   c. Anti-coagulants (blood thinners) ……..….. Yes No
   d. Cortisone (steroids) ……. Yes No
   e. Tranquilizers ……Yes No
   f. Anti-histamines (i.e. Benadryl, Claritin, Zyrtec) ……..... Yes No
   g. Aspirin ……..…… Yes No
   h. Insulin ……..…. Yes No
   i. Ritalin ……..…… Yes No
   j. Other; Explain: ……..…….. Yes No
10. Is your child ***allergic*** to any of the following types of medications?
   a. Local anesthetics ……. Yes No
   b. Penicillin, amoxicillin or other antibiotics …….. Yes No
   c. Sulfa drugs …….. Yes No
   d. Barbiturates, sedatives, sleeping pills ……..... Yes No
   e. Aspirin ……Yes No
   f. Codeine or other narcotics …….. Yes No
   g. Other; Explain: ……..…….. Yes No
11. Does your child have any mental &/or physical developmental delays? ……..……. Yes No
12. Does your child have any learning or behavioral problems? ……..…… Yes No
13. Does your child require any special considerations for dental treatment/care? ……..…….. Yes No
14. Does your child have any other medical condition(s) not listed above? ……..……... Yes No
   a. If yes, please explain: _____

I acknowledge that all the information I provide is accurate to the best of my knowledge.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

OFFICE STAFF ONLY

Birth history:

Birth weight:

Patient allergies:
Mom –
Dad –

Hospitalizations:

Medical alert(s):

Surgeries:

Sedation clearance:

Medications:

Last physical examination:

_____ _____

Dentist Signature Date

HA TO JACKLYNN THAI, D.D.S.
CHAO WEN WANG, D.D.S., M.S.
24700 CALAROGA AVE., SUITE 104
HAYWARD, CA. 94545
PHONE: 510-785-9295
FAX: 510-785-9412

PATIENT REGISTRATION

Date: _____

Patient's Last Name: _____ First Name: _____ Male: ____ Female: ____

Patient's D.O.B: _____ Age: _____ Patient's S.S#: _____

Address: _____ City: _____ Sate: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Emerg. Contact: _____ Phone: _____ Relationship to Patient: _____

How did you hear of us? Online: _____ Yellow Pages: _____ Friend: _____ Other: _____

PARENT INFORMATION

Mother's Name: _____ D.O.B: _____ S.S# _____

Employer: _____ Employer Phone Number: _____

Father's Name: _____ D.O.B: _____ S.S# _____

Employer: _____ Employer Phone Number: _____

PRIMARY INSURANCE INFORMATION

Subscriber Name: _____ D.O.B: _____ I.D. #: _____

Insurance Name: _____ Insurance Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group I.D #: _____

SECONDARY INSURANCE INFORMATION

Subscriber Name: _____ D.O.B: _____ I.D. #: _____

Insurance Name: _____ Insurance Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Group Name: _____ Group I.D #: _____

OVER

TERMS AND CONDITIONS

PAYMENT FOR DENTAL SERVICES: Insurance policies are contracts between you and the insurance company. To avoid misunderstandings regarding dental insurance, our professional services are charged directly to you and you are personally responsible for payment of fees. This dental office will help prepare the patient's insurance forms to assist in making collection from the insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

BROKEN APPOINTMENTS: A failed appointment fee of $45.00 per failed appointment may be charged for all appointments that are broken without a 48 hour cancellation notice. I agree to pay this fee if I fail to properly notify the office in the event of a cancellation. I am also aware that I must be on time for any scheduled appointments or the office has the option to reschedule my appointment.

WHAT WE DO:

- Provide you with and **ESTIMATE** of treatment and patient portions
- Prepare and mail the insurance claim form(s) on your behalf
- Send you an itemized statement each month of charges accrued &/or balances on your account

WHAT WE EXPECT OF YOU:

- Provide complete and accurate information
- Advise us of any changes to coverage or other patient information
- Pay your estimated patient portion at the time of each appointment
- Contact your insurance or employer if payment is not received within 60 days of treatment
- Forward to us insurance checks that are sent to you if you have a balance

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I have read the above "TERMS AND CONDITIONS" and hereby fully agree to their content. I hereby authorize the office of, **HA T. THAI, D.D.S., Inc.** and associates to render professional dental services on my child.

_____

Signature of parent or guardian Date

_____

Print Name Relationship to patient