PATIENT ACQUAINTANCE FORM

Date _____ Whom may we thank for referring you to our office?_____

Name _____ Nickname_____ Date of Birth _____

□ Mrs. □ Ms. □ Mr. □ Dr. ● □ Male □ Female

DENTAL HISTORY

- When was your last dental visit? _____
- When was your last set of full mouth x-rays taken? _____
- How often do you brush / floss your teeth? _____
- Do your gums bleed when you brush or floss? □ Yes □ No
- Have you ever been treated for periodontal disease (gum disease)? □ Yes □ No
- Have you ever had orthodontic treatment? □ Yes □ No
- Have you ever had injury to your face or jaws? □ Yes □ No

  If yes, please explain _____
- Do you ever have clicking, popping or discomfort in your jaw joints? □ Yes □ No
- Do you grind / brux or clench your teeth? □ Day or □ Night □ Yes □ No
- Do you have sores, blisters or swelling on your gums, lips or checks? □ Yes □ No

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? Please check the appropriate boxes.
If yes to any of the starred conditions, please call prior to your appointment…premedication may be required.

☐ Heat Failure	☐ Emphysema	☐ Hepatitis Type A B C
☐ Heart Disease or Attack	☐ Tuberculosis (TB)	☐ High Risk
☐ Angina Pectoris	☐ Asthma or Hay Fever	☐ Liver Disease
☐ High Blood Pressure	☐ Sinus Trouble	☐ Yellow Jaundice
☐ Heart Murmur*	☐ Allergies or Hives	☐ Drug Addiction
☐ Rheumatic fever*	☐ Diabetes	☐ Hemophilia
☐ Congenital Heart Lesions*	☐ Thyroid Disease	☐ Venereal Disease
☐ Scarlet Fever	☐ Radiation Therapy	☐ Epilepsy or Seizures
☐ Artificial Heart Valve*	☐ Glaucoma	☐ Nervousness
☐ Heart Pacemaker*	☐ Pain in Jaw Joints	☐ Psychiatric Treatment
☐ Heart Surgery	☐ Bruise Easily	☐ Sickle Cell Disease
☐ Mitral Valve Prolapse*	☐ Kidney Trouble	☐ Leukemia
☐ Artificial Joint*	☐ Ulcers	☐ HIV
☐ Anemia	☐ Benign Tumor	☐ A.I.D.S. or A.R.C.
☐ Stroke	☐ Cortisone Therapy	☐ Other
☐ Cancer _____	☐ Arthritis or Rheumatism	

MEDICAL HEALTH HISTORY

- Are you in good health? Date of last physical examination: _____ □ Yes □ No
- Are you now under the care of a physician? □ Yes □ No

  Physician's name:_____ Phone Number:_____

  Address:_____ Kaiser Medical #_____
- Have you ever had any serious illness or had an operation?_____ □ Yes □ No
- Have you ever been hospitalized? If so, when and what was the problem_____ □ Yes □ No
- Are you now currently taking any prescription medications or drugs? □ Yes □ No

  If so, please list: _____
- Are you **ALLERGIC** to any medications or substances?_____ □ Yes □ No

  □ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex Rubber □ Sulfa □ _____
- Have you ever had any excessive or prolonged bleeding requiring special treatment? □ Yes □ No
- Have you ever been denied permission to donate blood? □ Yes □ No
- When you walk up stairs or take a walk, do you ever have to stop because of a pain in your chest, shortness of breath, or because you are very tired? □ Yes □ No
- Do your ankles swell during the day? □ Yes □ No
- Do you smoke or chew tobacco? If so, how much and for how long? _____ □ Yes □ No
- Are you on a special diet? □ Yes □ No
- Do you have any disease, condition or problem not listed? □ Yes □ No

  If so, please explain _____

FOR WOMEN ONLY

- Are you pregnant now? What trimester _____ □ Yes □ No
- Are you taking birth control pills? □ Yes □ No
- Do you anticipate becoming pregnant? □ Yes □ No
- Are you nursing presently? □ Yes □ No

ADDITIONAL COMMENTS

_____

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and careful manner. I have answered all questions truthfully and to the best of my knowledge.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
DENTIST SIGNATURE DATE

Bay Area Prosthodontics - Jung Nam, DMD, MSD & Douglas S. Lew, DDS
1691 El Camino Real, Suite #200 Palo Alto, CA 94306

RESPONSIBLE PARTY INFORMATION

Patient Name: _____Date of Birth_____ Soc.Sec. _____

If patient is a full time student? Name of school_____State_____

Name of person responsible for this account: _____

Address _____ City_____ State_____Zip Code_____

Home # _____ Business # _____Cellular # _____

E-Mail Address _____

Emergency Contact Name: _____ Phone # _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name _____ D.O.B. _____ Soc Sec. _____

Insured's Employer _____Phone #_____

Insurance Company _____Group # _____

Insurance ID No._____Insurance Co. Phone # _____

Do you have another insurance coverage? □ Yes □ No

If yes, Please complete the following secondary insurance information.

SECONDARY INSURANCE

Insured's Name _____ D.O.B. _____ Soc. Sec. _____

Insured's Employer _____Phone # _____

Insurance Company _____Group # _____

Insurance ID No._____Insurance Co. Phone # _____

CONSENT FOR TREATMENT

The undersigned hereby authorizes the health care provider to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs and treatment. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.

I authorize the dentist to release any information including diagnosis and the records of any treatment of examination rendered to me during the period of such dental care to third party payors and/or other health practitioners.

I understand that my insurance(s) will be billed and submitted as a courtesy to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that all responsibility for payment for dental services provided in this office for myself or any of my dependents is mine, due and payable at the time services are rendered unless other financial arrangements have been made. In the event payments are not received by the agreed upon dates, I understand a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection fees. I understand that any appointment cancelled with less then 48 hrs. notice is subject to charge. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

_____ _____

PATIENT SIGNATURE OR LEGAL GUARDIAN DATE