



Aliso Shore Dentistry

6B LIBERTY, SUITE 120
ALISO VIEJO, CA 92656

Patient
Number _____

Patient Information (Confidential)

To help us meet all your health care needs, please fill out the form completely in ink.
If you have any questions or need assistance, please ask us and we will be happy to help.

Name _____ Date _____

SS#/SIN _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell phone _____

Check Appropriate Box: Minor Single Married Separated Divorced Widowed

If Student Name of School/College _____ City _____ State/Prov. _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ Work phone _____

Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to patient _____

Address _____ Home Phone _____

Email _____ Cell phone _____

Driver's license # _____ Birthdate _____ Financial institution _____

Employer _____ Work phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? Yes No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Checks Credit Card Visa MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ To Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins.Co.Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Do You Have Any Additional Insurance? Yes No If Yes, Complete the Following

Name of Insured _____ To Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local# _____ Work phone _____

Employer Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins.Co.Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

(over please)

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

<p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____</p> <p>3. Are you taking any medication(s) including non-prescription medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what medication(s) are you taking? _____</p> <p>4. Have you ever taken Fen-Phen/Redux? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you ever taken Bisphosphonates? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you have or have you had any of the following:</p> <table border="0"> <tr> <td style="text-align: right;">High Blood Pressure</td> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Heart Attack</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Rheumatic Fever</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Swollen Ankles</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Fainting/Seizures</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Asthma</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Low Blood Pressure</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Epilepsy/Convulsions</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Leukemia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Diabetes</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Kidney Diseases</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">AIDS or HIV Infection</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Thyroid Problems</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	High Blood Pressure	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>10. Are you allergic to or have you had the reactions to the following?:</p> <p>Local Anesthetics (e.g. Novocaine)..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sulfur Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Barbiturates <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Any Metals (e.g. nickel, mercury, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other _____</p> <p>11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Women only:</p> <p>Are you pregnant or think you may be pregnant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you taking oral contraceptives?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
High Blood Pressure	Yes	No	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																														

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

<p>1. Do your gums bleed while brushing or flossing?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Had a sores or lumps in or near your mouth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in your jaw?</p> <table border="0"> <tr> <td style="text-align: right;">Clicking.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Pain (joint, ear, side of face).....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Difficulty in opening or closing.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: right;">Difficulty in chewing.....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>	Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>	<p>8. Do you have frequent headaches?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had prolonged bleeding following extractions?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Clicking.....	<input type="checkbox"/>	<input type="checkbox"/>											
Pain (joint, ear, side of face).....	<input type="checkbox"/>	<input type="checkbox"/>											
Difficulty in opening or closing.....	<input type="checkbox"/>	<input type="checkbox"/>											
Difficulty in chewing.....	<input type="checkbox"/>	<input type="checkbox"/>											

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group

insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient (or parent/guardian if minor)

Patient Acknowledgements:

- I understand that all charges incurred are payable in full at time of service. Initial _____
- I consent to the taking of radiographs and/or photographs before and during treatment for diagnostic purposes and for the use by the same dentist in scientific papers or demonstrations. Sign _____
- I consent to the publication of my photos released to Dr. Yang & Dr. Nguyen by any other healthcare providers. Sign _____
- I certify that I have read (or have read to me), understand and agree to the contents of this form. Sign _____

I have read the above. Signature _____ Date _____
Parents or Guardians if minor

Doctor's comments _____
Signature _____ Date _____