PATIENT INFORMATION

First Name:________________ MI:______ Last:________________ Preferred Name: ____________

Cell Phone:________________ Email address:________________ Appointment reminders (circle preference): Text or Email

DOB:________________ □ Male □ Female SS#: ________________

Address:________________ City:________________ State:______ Zip: ____________

Employer/Occupation: ________________

Name of Physician:________________ Physician Phone: ________________

In case of Emergency Contact:________________ Relationship:____________ Phone: ____________

How did you hear about our office? ________________

RESPONSIBLE PARTY INFO IF PATIENT UNDER THE AGE OF 18:

First Name:________________ MI:______ Last:________________ Preferred Name: ____________

Cell Phone:________________ Email address:________________ Appointment reminders (circle preference): Text or Email

DOB:________________ □ Male □ Female SS#: ________________

Address:________________ City:________________ State:______ Zip: ____________

Employer/Occupation: ________________

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to Eastview Family Dental/BM Fong PLLC at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service(if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the Practice may charge: 1) a late fee if payment on my account is not received by the due date; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a $50.00 fee for each appointment that is missed/canceled without at least 48 hours advance notice. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the Eastview Family Dental/BM Fong PLLC. ______ (patient initials)

DENTAL INSURANCE INFORMATION:

Primary Insurance:

Primary **Dental** Insurance Name:________________ Phone Number:________________

ID Number:________________ Group Number: ________________

Name Subscriber:________________ Relationship:____________ DOB of Subscriber: ____________

Secondary Insurance:

Secondary **Dental** Insurance Name:________________ Phone Number:________________

ID Number:________________ Group Number: ________________

Name Subscriber:________________ Relationship:____________ DOB of Subscriber: ____________

I acknowledge having received a copy of the Practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: ________________ Date: ____________

(To be signed even if Patient is also the Responsible Party)

MEDICAL HISTORY

Patient Name ______________________ Nickname ______________ Age ______

Name of Physician/and their specialty ______________________

Most recent physical examination ______________________ Purpose ______________________

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury ______	☐	☐
2.	an allergic reaction to ______	☐	☐
	☐ aspirin, ibuprofen, acetaminophen, codeine ☐ penicillin ☐ erythromycin ☐ tetracycline ☐ sulfa ☐ local anesthetic ☐ fluoride ☐ metals (nickel, gold, silver, ______) ☐ latex ☐ other ______		
3.	heart problems, or cardiac stent within the last six months ___	☐	☐
4.	history of infective endocarditis ______	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) ______	☐	☐
6.	pacemaker or implantable defibrillator ______	☐	☐
7.	orthopedic implant (joint replacement) ______	☐	☐
8.	rheumatic or scarlet fever ______	☐	☐
9.	high or low blood pressure ______	☐	☐
10.	a stroke (taking blood thinners) ______	☐	☐
11.	anemia or other blood disorder ______	☐	☐
12.	prolonged bleeding due to a slight cut (INR > 3.5) ______	☐	☐
13.	emphysema, shortness of breath, sarcoidosis ______	☐	☐
14.	tuberculosis, measles, chicken pox ______	☐	☐
15.	asthma ______	☐	☐
16.	breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17.	kidney disease ______	☐	☐
18.	liver disease ______	☐	☐
19.	jaundice ______	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency ______	☐	☐
21.	hormone deficiency ______	☐	☐
22.	high cholesterol or taking statin drugs ______	☐	☐
23.	diabetes (HbA1c = ______) ______	☐	☐
24.	stomach or duodenal ulcer ______	☐	☐
25.	digestive disorders (i.e. celiac disease, gastric reflux) ______	☐	☐
26.	osteoporosis/osteopenia (i.e. taking bisphosphonates) ______	☐	☐
27.	arthritis ______	☐	☐
28.	autoimmune disease ______ (i.e. rheumatoid arthritis, lupus, scleroderma)	☐	☐
29.	glaucoma ______	☐	☐
30.	contact lenses ______	☐	☐
31.	head or neck injuries ______	☐	☐
32.	epilepsy, convulsions (seizures) ______	☐	☐
33.	neurologic disorders (ADD/ADHD, prion disease) ______	☐	☐
34.	viral infections and cold sores ______	☐	☐
35.	any lumps or swelling in the mouth ______	☐	☐
36.	hives, skin rash, hay fever ______	☐	☐
37.	STI / STD / HPV ______	☐	☐
38.	hepatitis (type ___) ______	☐	☐
39.	HIV / AIDS ______	☐	☐
40.	tumor, abnormal growth ______	☐	☐
41.	radiation therapy ______	☐	☐
42.	chemotherapy, immunosuppressive medication ______	☐	☐
43.	emotional difficulties ______	☐	☐
44.	psychiatric treatment ______	☐	☐
45.	antidepressant medication ______	☐	☐
46.	alcohol / recreational drug use ______	☐	☐

ARE YOU:

		YES	NO
47.	presently being treated for any other illness ______	☐	☐
48.	aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) ______	☐	☐
49.	taking medication for weight management ______	☐	☐
50.	taking dietary supplements ______	☐	☐
51.	often exhausted or fatigued ______	☐	☐
52.	experiencing frequent headaches ______	☐	☐
53.	a smoker, smoked previously or use smokeless tobacco _	☐	☐
54.	considered a touchy / sensitive person ______	☐	☐
55.	often unhappy or depressed ______	☐	☐
56.	taking birth control pills ______	☐	☐
57.	currently pregnant ______	☐	☐
58.	prostate disorders ______	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature ______________________ Date ______________

Doctor's Signature ______________________ Date ______________

ASA ______ (1-6) ◯ ◯ ◯

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DENTAL HISTORY

Name______________________________ Nickname______________________________ Age__________
Referred by__________________________ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist ______________________________ How long have you been a patient?__________ Months/Years__________
Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
Date of most recent treatment (other than a cleaning) ____/____/____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? ______________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING: YES NO

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] ______ ☐ ☐
2. Have you had an unfavorable dental experience? ______ ☐ ☐
3. Have you ever had complications from past dental treatment? ______ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? ______ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ______ ☐ ☐
6. Have you had any teeth removed or missing teeth that never developed? ______ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ______ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ______ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? ______ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? ______ ☐ ☐
11. Have you ever experienced gum recession? ______ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? ______ ☐ ☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? ______ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ______ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? ______ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ______ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? ______ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? ______ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? ______ ☐ ☐
20. Do you frequently get food caught between any teeth? ______ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ______ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? ______ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? ______ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? ______ ☐ ☐
25. Are your teeth becoming more crooked, crowded, or overlapped? ______ ☐ ☐
26. Are your teeth developing spaces or becoming more loose? ______ ☐ ☐
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? ______ ☐ ☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? ______ ☐ ☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ______ ☐ ☐
30. Do you clench your teeth in the daytime or make them sore? ______ ☐ ☐
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? ______ ☐ ☐
32. Do you wear or have you ever worn a bite appliance? ______ ☐ ☐

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ______ ☐ ☐
34. Have you ever whitened (bleached) your teeth? ______ ☐ ☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? ______ ☐ ☐
36. Have you been disappointed with the appearance of previous dental work? ______ ☐ ☐

Patient's Signature ______________________________ Date __________
Doctor's Signature ______________________________ Date __________

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