Patient Name

NEW PATIENT FORM

Chart No.

Medical Alert

Patient Information

Name: _____ Birthdate: _____ /_____ /_____
First Middle Last
Mailing Address: _____
Street City State Zip Code
Home phone: ( ) _____ Work phone: ( ) _____ Email: _____
Which phone number is the best to get ahold of you? _____
Sex: ☐M ☐F Marital status: ☐Single ☐Married ☐Divorced ☐Separated ☐Partnership ☐Widowed ☐I prefer not to answer
Employer or School: _____ Phone: ( ) _____
Address: _____
Street City State Zip Code
Spouse, partner or parent name: _____
Emergency contact name: _____ Phone number: ( ) _____ Relationship: _____
How did you learn about our practice or whom may we thank for referring you? _____

Dental Insurance

Primary Insured/Subscriber: _____
Date of Birth: _____ /_____ /_____ Social Security # _____-_____-_____ OR Insurance ID #_____
Relationship to patient: _____
Insurance Company: _____ Employer: _____
Group # _____

Secondary Insured/Subscriber: _____
Date of Birth: _____ /_____ /_____ Social Security # _____-_____-_____ OR Insurance ID #_____
Relationship to patient: _____
Insurance Company: _____ Employer: _____
Group # _____

If Minor or applicable, Parent or Guardian Information
Father/Mother name: _____
First Middle Last
Address: _____
Street City State Zip Code Phone number: ( ) _____
Father/Mother name: _____
First Middle Last
Address: _____
Street City State Zip Code Phone number: ( ) _____
Emergency Contact: _____
Name Phone number: ( ) _____

Authorization

I hereby authorize Lin Teng, Karen Lin DDS, Inc to administer such treatment and perform such diagnostic, photographic and therapeutic procedures as many be necessary for proper dental care. The information on this page and the dental and medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and or health professionals.

x _____ Date _____
Patient or Responsible Party

Patient Name

Chart No.

DENTAL HISTORY

Medical Alert

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.

All information is completely confidential

What is the reason for your visit today? _____

Date of Last Dental Visit? _____ Last Dental Cleaning? _____ Last X-rays _____

What was done at your last dental visit? _____

How often do you brush? ☐ 2-3 times/day ☐ 1-2 times/day ☐ Sometimes a week ☐ Rarely ☐ Never

How often do you floss? ☐ 2-3 times/day ☐ 1--2 times/day ☐ Sometimes a week ☐ Rarely ☐ Never

Have you ever used or are you currently using a topical fluoride? ☐Yes☐No

What other dental aids do you use (Waterpik, toothpick,etc.)? ☐Yes☐No

Have you had any problems or unsetting experience with previous dental treatment? ☐Yes☒No

If yes, please describe _____

How do you feel about your smile? _____

Are any of your teeth sensitive to:

Hot or cold? . . . . . ☐Yes☐No

Sweet or pressure? . . . . . ☐Yes☐No

Biting or chewing? . . . . . ☐Yes☐No

Have you noticed any mouth odors/bad taste? . . . . . ☐Yes☐No

Do you frequently get cold sores, blisters or any other oral lesions? . . . . . ☐Yes☐No

Do your gums bleed or hurt when brushing or flossing? ☐Yes☐No

Have your parents experience from gum disease or tooth loss? . . . . . ☐Yes☐No

Have you noticed any loose teeth or changes in bite? . . ☐Yes☐No

Does food tend to become caught in between your teeth? . . . . . ☐Yes☐No

If yes, where? _____

Are you currently experiencing dental pain/discomfort? ☐Yes☐No

Do you:

Clench or grind your teeth while awake or asleep? . . . . ☐Yes☐No

Bitey our lips or cheeks regularly? . . . . . ☐Yes☐No

Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)? . . . . . ☐Yes☐No

Mouth breathe while awake or asleep? . . . . . ☐Yes☐No

Have tired jaws, especially in the morning? . . . . . ☐Yes☐No

Snore or have any other sleeping disorders? . . . . . ☐Yes☐No

Smoke/chew tobacco or use other tobacco products? . . . . . ☐Yes☐No

Have you ever had:

Dentures or partials? . . . . . ☐Yes☐No

Crowns and bridges? . . . . . ☐Yes☐No

Orthodontic treatment? . . . . . ☐Yes☐No

Oral surgery? . . . . . ☐Yes☐No

Periodontal treatment? . . . . . ☐Yes☐No

Your teeth ground or the bite adjusted? . . . . . ☐Yes☐No

A bite plate or mouth guard? . . . . . ☐Yes☐No

A serious injury to the mouth or head? . . . . . ☐Yes☐No

If yes, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw . . . . . ☐Yes☐No

Pain (joint, ear, side of face)? . . . . . ☐Yes☐No

Difficulty in opening or closing the mouth? . . . . . ☐Yes☐No

Difficulty in chewing? . . . . . ☐Yes☐No

Headaches, neck aches or shoulder aches? . . . . . ☐Yes☐No

Sore muscles (neck, shoulders)? . . . . . ☐Yes☐No

Anxiety or nervousness about dental treatment? . . . ☐Yes☐No

If so, what is your biggest concern? _____

Have you ever been told to take a pre-medication prior to dental treatment? _____

Is there anything else about having dental treatment that you would like us to know?

If yes, please describe _____

Patient Name

Chart No.

MEDICAL HISTORY

Medical Alert

1. Are you currently under the care of a physician? . . . . . ☐Yes☐No ☐DK
   Physician's Name _____ Phone ( ) _____
2. Has there been any change in your general health within the past year? . . . . . ☐Yes☐No
   Describe _____
3. Have you been a patient in the hospital during the past five years? . . . . . ☐Yes☐No
   If yes, please describe the illness or problem _____
4. Have you taken any medications or drugs during the past two years? . . . . . ☐Yes☐No
5. Are you currently taking any medication, drugs, pills or herbal remedies, including regular dosages of aspirin? . . . . . ☐Yes☐No
   If so, please list all including vitamins, natural herbal preparations and/or diet supplements:
   _____
   _____
   _____
6. **Joint Replacement.** Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement . . . . . ☐Yes☐No
   Date: _____ If yes, any complications? _____
7. Have you ever taken prescription medications for weight loss (diet pills)? . . . . . ☐Yes☐No
   If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimin ☐ Redux ☐ Other
   If yes to any of the above, did you have a medical exam for heart issues? . . . . . ☐Yes☐No
8. Are you taking or scheduled to take alendronate (Fosamax®), risedronate (Actonel®) or other similar drugs for osteoporosis or Paget's disease . . . . . ☐No☐Yes: _____
9. Since 2001, were you treated or are you scheduled to start treatment with the intravenous bisphosphonates (Aredia ®or Zometa ®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? . . . . . ☐Yes☐No ☐DK
   Date Treatment began: _____
10. Are you aware of having an allergic (or adverse) reaction to any substance or medications? . . . . . ☐Yes☐No
    If yes, circle applicable ones:

Local anesthetics	Aspirin	Penicillin or other antibiotics	
Barbiturates, sedatives, or sleeping pills	Sulfa drugs	Codeine or other narcotics	
Metals	Latex (rubber)	Iodine	Hay fever
Seasonal	Animals	Food	Other

11. Indicate which of the following you have had, or have at the present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack) . . ☐Yes☐No
Chest Pain . . . . . ☐Yes☐No
Congenital Heart Disease . . . . . ☐Yes☐No
- Unrepaired cyanotic CHD . . . . . ☐Yes☐No
- Completely Repaired in last 6 mo . . . ☐Yes☐No
- Repaired CHD with residual defects ☐Yes☐No
- Other _____

Heart Murmur . . . . . ☐Yes☐No
High/Low Blood Pressure . . . . . ☐Yes☐No
Mitral Valve Prolapse . . . . . ☐Yes☐No
Artificial (prosthetic) Heart Valve. . ☐Yes☐No
Damaged vales in transplanted heart . . . . . ☐Yes☐No
Pacemaker . . . . . ☐Yes☐No
Rheumatic Fever . . . . . ☐Yes☐No
Arthritis/Rheumatism . . . . . ☐Yes☐No
Cortisone Medicine . . . . . ☐Yes☐No
Swollen Ankles . . . . . ☐Yes☐No
Stroke . . . . . ☐Yes☐No

Diet (Special/Restricted) . . . . . ☐Yes☐No
Kidney Trouble . . . . . ☐Yes☐No
Ulcers . . . . . ☐Yes☐No
Diabetes . . . . . ☐Yes☐No
Thyroid Problems . . . . . ☐Yes☐No
Glaucoma . . . . . ☐Yes☐No
Contact Lenses . . . . . ☐Yes☐No
Emphysema . . . . . ☐Yes☐No
Chronic Cough . . . . . ☐Yes☐No
Tuberculosis . . . . . ☐Yes☐No
Asthma . . . . . ☐Yes☐No
Hay Fever/Allergy/Hives . . . . ☐Yes☐No
Latex Sensitivity . . . . . ☐Yes☐No
Sinus Trouble . . . . . ☐Yes☐No
Radiation Therapy . . . . . ☐Yes☐No
Chemotherapy . . . . . ☐Yes☐No
Tumors . . . . . ☐Yes☐No
Hepatitis A, B, C . . . . . ☐A☐ B☐C

Venereal Disease . . . . . ☐Yes☐No
AIDS/HIV Positive . . . . . ☐Yes☐No
Cold Sores/Fever Blisters . . . . ☐Yes☐No
Blood Transfusion . . . . . ☐Yes☐No
Hemophilia . . . . . ☐Yes☐No
Sickle Cell Disease . . . . . ☐Yes☐No
Bruise Easily . . . . . ☐Yes☐No
Liver Disease / Jaundice. . . . . ☐Yes☐No
Neurological Disorders . . . . . ☐Yes☐No
Epilepsy or Seizures . . . . . ☐Yes☐No
Fainting or Dizzy Spells . . . . . ☐Yes☐No
Nervous/Anxious . . . . . ☐Yes☐No
Psychiatric/Psychological Care . . . . . ☐Yes☐No

12. Do you use controlled substances (drugs)? . . . . . ☐Yes☐No
13. Do you use tobacco (smoking, snuff, chew, bidis)? . . . . . ☐Yes☐No
    If so, how interested are you in stop? (Circle one) VERY / SOMEWHAT / NOT INTERESTED
14. Do you drink alcoholic beverages? . . . . . ☐Yes☐No
    If yes, how much alcohol did you drink in the last 24 hours? _____
    If yes, how much do you typically drink in a week? _____
15. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?
16. Name of physician or dentist making recommendation:
17. Have you lost or gained more than 10 pounds in the last year? . . . . . ☐Yes☐No
18. Do you have or have you had any disease, condition, or problem not listed above that you think I should know about? . . . . . ☐Yes☐No
    Please explain: _____
19. Women: Are you pregnant or think you could be pregnant? ☐Yes _____ Months ☐No Nursing? ☐Yes☐No
20. Women: Do you use birth control prescriptions? . . . . . ☐Yes☐No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review _____ Date _____

Dentist Signature _____ Date _____