

**Patient Information**

Date \_\_\_\_\_  
Patient's Name \_\_\_\_\_  
Last First Middle  
Address \_\_\_\_\_  
Street City State Zip  
Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
If patient is a minor, give parent's or guardian's name \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
Last First Middle Marital Status  
Residence \_\_\_\_\_  
Street City State Zip  
Mailing Address \_\_\_\_\_  
Street City State Zip  
How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_  
Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First Middle  
Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

**Dental Insurance Information**

Insured's Name \_\_\_\_\_ Insured Soc. Sec. # \_\_\_\_\_  
Insured's Birthdate \_\_\_\_\_ Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_

*Signature on File For Dental Insurance: I authorize Dr. Ronald Yee's office to file my dental insurance claims electronically or by conventional means on dental treatment authorized by me on the day the claim is filed. I authorize the assignment of dental benefits otherwise payable to me to Dr. Ronald Yee's office. My signature on file for dental insurance will remain active until I inform the office in writing to change or terminate this arrangement.*

\_\_\_\_\_  
Signature of patient or legal guardian Date

**Consent for dental treatment and office policies:**

- 1. I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy. I understand that using anesthetic agents embodies a certain risk, as does all restorative dental treatment. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatments, including referrals to dental specialists.
- 2. I agree to honor my appointment and financial policies of this office. I agree to pay the prevailing rescheduling fee if I do not reschedule my appointments with at least 48 business hours of notice to the doctor's office.
- 3. I understand that all responsibility for payment for dental services provided in this office or my dependents is mine, and not that of the insurance carrier. I agree to pay for services at the time services are rendered unless other financial arrangements have been made. If I have insurance that is verified, I agree to pay my expected portion of the treatment not covered by insurance on the day service is rendered. In the event that payments are not received by the agreed upon dates, I agree that the prevailing rebilling fee will be added to my account.
- 4. I agree to inform this office immediately of any changes in my health history, benefits, and home and work information prior to the next schedules appointment.

Patient \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_  
If minor, Parent or responsible party \_\_\_\_\_  
In case of emergency, Name/Phone# of relative not living with you: \_\_\_\_\_

PLEASE ANSWER ALL QUESTIONS COMPLETELY (Numbers 1-13)

**PATIENT MEDICAL HEALTH RECORD**

DATE: \_\_\_\_\_

- 1) Name and address of physician \_\_\_\_\_
- 2) Have you been under a physician's care during the past 2 years? \_\_\_\_\_ For \_\_\_\_\_
- 3) Have you been treated in a hospital in the past 2 years? \_\_\_\_\_ For \_\_\_\_\_
- 4) Have you ever had major surgery? \_\_\_\_\_ For \_\_\_\_\_
- 5) Have you ever had a major accident? \_\_\_\_\_ Year \_\_\_\_\_ What kind \_\_\_\_\_
- 6) If female: Are you taking hormones or birth control? \_\_\_\_\_ Are you pregnant or nursing? \_\_\_\_\_
- 7) Have you ever had a blood test for hepatitis? \_\_\_\_\_ Were you vaccinated for hepatitis? \_\_\_\_\_
- 8) Have you had cankers or cold sores on your lips, tongue, gums or body? \_\_\_\_\_
- 9) Are you now taking or have you taken any prescription drugs during the past year? \_\_\_\_\_ For \_\_\_\_\_  
Please list medication(s) \_\_\_\_\_

- 10) Are you allergic to:
- |   |  |
|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Penicillin | Yes <input type="checkbox"/> No <input type="checkbox"/> Local Anesthetics     |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Codeine    | Yes <input type="checkbox"/> No <input type="checkbox"/> Other Allergies _____ |

11) Height \_\_\_\_\_ Weight \_\_\_\_\_

12) Have you had or do you have:

- |                               |  |                                     |  |
|-------------------------------|--|-------------------------------------|--|
| AIDS/HIV.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Hepatitis.....                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Abnormal Blood Pressure.....  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Herpes.....                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Allergies.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Jaundice.....                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Anemia.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Kidney Disease.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Angina.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Liver Disease.....                  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Arthritis.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> | Organ Transplant.....               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Heart Valves.....  | Yes <input type="checkbox"/> No <input type="checkbox"/> | Pacemaker.....                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Artificial Joints.....        | Yes <input type="checkbox"/> No <input type="checkbox"/> | Polio.....                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Asthma.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Prolonged Bleeding.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cancer.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> | Prolonged Cough.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Chemotherapy.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Psychiatric Treatment.....          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Congenital Heart Lesions..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | Radiation Therapy.....              | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Diabetes.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Rheumatic Fever.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Drug Dependency.....          | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sickle Cell Anemia.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Epilepsy.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Stroke.....                         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Fainting.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Taken Phen Phen or Redux.....       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Glaucoma.....                 | Yes <input type="checkbox"/> No <input type="checkbox"/> | Smoke/ Chewing Tobacco.....         | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart disease.....            | Yes <input type="checkbox"/> No <input type="checkbox"/> | Consume Alcohol.....                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Heart murmur.....             | Yes <input type="checkbox"/> No <input type="checkbox"/> | Previous Negative dental visit..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|                               |  | HIV Positive.....                   | Yes <input type="checkbox"/> No <input type="checkbox"/> |

13) Have you any disease, condition, or problem not previously listed? \_\_\_\_\_

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