# ROGER C. HO, D.D.S.

*GENERAL & COSMETIC DENTISTRY*

Name _____ Date _____
First Middle Last

Address _____ City _____ State _____ Zip _____

Cell # _____ Home phone _____ Soc. Security # _____ Birthdate _____

Email address _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced

If college student, F.T/P.T., name of school _____ City _____ State _____

Employer _____ Work phone _____

How did you hear about us? ☐ Friend/ Family ☐ Insurance ☐ Yelp ☐ Mailer ☐ Other _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

## Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Phone number _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

## Insurance Information

Name of primary subscriber _____ Relationship to patient _____

Primary subscriber's birthday _____ Soc. Security # _____

Name of employer _____ Work phone _____

Name of Dental Insurance _____ Tel. # _____ Grp. # _____

Policy/I.D.# _____ Insurance effective date _____

Do you have any additional insurance ☐ Yes ☐ No If yes, Name of your dental insurance _____

Name of primary subscriber _____ DOB _____

## Authorization

*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 my child or me during the period of such dental care to third party payers 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 if minor)* **DATE**

# ROGER C. HO, D.D.S.

*GENERAL & COSMETIC DENTISTRY*

## HEALTH HISTORY

**Patient Name:** _____ **Birth Date:** _____

**I. CIRCLE APPROPRIATE ANSWER** (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam? _____ Date of last Dental exam _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

**II. HAVE YOU EXPERIENCED:**

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness

**III. DO YOU HAVE OR HAVE YOU HAD:**

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Family history of diabetes, heart problems, tumors?
39. Yes No Allergies to: ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Other: _____
40. Yes No AIDS, HIV?
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

**IV. DO YOU HAVE OR HAVE YOU HAD:**

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint? _____
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries? _____
59. Yes No Pacemaker?

**V. ARE YOU TAKING:**

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

**LIST OF MEDICATIONS:** _____

**VI. WOMEN ONLY:**

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

**VII. ALL PATIENTS:**

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: _____

*To the best of my knowledge, I have answered every question completely an accurately. I will inform my dentist of any change in my health and/or medication.*

Patient's signature: _____ Date: _____