Brian J. Wong, D.D.S.
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Welcome To Our Office!

In order to serve you properly, we will need the following information (please print). All information will be strictly confidential.

A.

Patient Name: (Marital Status: _____) Spouse: _____ Date: _____

_____
Last First Middle Initial "Nickname"

Address _____
(If P.O. Box, please give street address also)

City _____ State _____ Zip _____ CEL PHONE _____

Home Phone _____ Work _____ Ext _____ Sex M ___ F ___

Date of Birth _____ Social Security Number _____-_____-_____ Dr License # _____

Employer's Name & Address _____

Closest Relative, not living w/you: Name, phone, & Address _____

Whom may we thank for referring you? _____

Other than Spouse, Alternate (emergency) Phone _____ Name _____ Relationship _____

B. Responsible Party Information (If different from above)

Name of responsible party _____ Dr License # _____

Address _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Ext _____ **Birthdate** _____ Sex M/F

Employer's Name _____ Social Security Number _____-_____-_____

C. Payment or verification of insurance coverage is required at the time of treatment. For payment of fees or for paying your portion of fees not covered by insurance, we accept the following payment options. Please indicate your choice(s) of payment. We are happy to answer any questions you may have.

Cash ___ Check ___ Credit Card ___ Finance Company ___

Do you have dental insurance? Yes ___ No ___

Name of Insurance Company _____

Address of Insurance Company _____

Name of Insured Person _____ Soc Sec # or I.D.# _____ Military Rank _____

Employer/Group Plan of Insured _____ Group # _____

D.

What is the purpose of your visit today? _____

_____

Are you having any pain or discomfort today? _____

How do you feel about visiting the dentist? _____

_____

PLEASE COMPLETE NEXT PAGE ALSO

last x-rays? _____

E. DENTAL HISTORY

When was your last dental exam? _____ last cleaning? _____

Is there anything you dislike about the appearance and/or function of your teeth? _____

_____

How do you take care of your teeth on a daily basis? (circle the methods which apply)

Brushing Flossing Mouthwash Other:_____

F. **MEDICAL HISTORY**

Please circle any of the following which may apply to you now or in the past:

Heart Failure	Stroke	Shingles	Liver Disease	Drug Abuse
Heart Disease or attack	High Blood Pressure	Hemophilia	Yellow Jaundice	Alcoholism
Artificial Heart Valve	Heart Pacemaker	Diabetes	Drug Addiction	Radiation Therapy
Artificial Joint/Implants	Congenital Heart Lesions	Thyroid Disease	Venereal Disease	Herpes/Cold sore
Mitral Valve Prolapse	Angina Pectoris	Sinus trouble	Glaucoma	Blood Transfusion
Heart Murmur	Pain in Jaw Joints	Heart Surgery	Epilepsy or Seizures	Emphysema
Rheumatic Fever	Hepatitis A (infectious)	AIDS	Fainting or Dizzy Spells	Tuberculosis
Asthma	Hepatitis B (serum)	HIV positive	Bruise Easily	Allergies or Hives
Cancer or Tumors	Kidney Disease	Scarlet Fever	Chemotherapy	Fever Blisters

Any other diseases or health problems?_____

WOMEN: Are you pregnant? _____ If so, what is your due date? _____

Have you ever had an unusual reaction or an allergic reaction to an anesthetic or drug such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, ETC.? Yes ___ No ___ If yes, please explain:

_____

Medications taking at present:_____

_____

List any surgeries you have had in the past 5 years: _____

_____

Who is your medical doctor? _____ Phone Number _____

G. I understand that the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I authorize the doctor to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to thoroughly diagnose dental needs. I also authorize the doctor to choose and employ assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided by this office for myself or my dependents is mine, due and payable at the time services are rendered unless other financial arrangements are made. In the event of default I (we) promise to pay legal interest on the indebtedness, together with all collection costs and reasonable attorney fees as may be required to effect the collection of this note. **Fees not paid by the insurance company within 60 days, are due and payable from the patient or the responsible party.**

Patient_____ Date _____

Parent or Responsible Party _____ Relationship to Patient _____

H. I hereby authorize my insurance benefits to be paid directly to doctor Brian J. Wong, D.D.S. and/or Viveca J. Valeriano, D.D.S. I also authorize the Doctor to release any information required to process insurance claims.

Date _____ Signature _____
(insured person)

Date _____ Signature _____
(patient, or parent/guardian of minor patient)

Date _____ Doctor's Signature _____